



## **Adult D Safeguarding Adult Review Learning Brief** **Publication Date: 13 March 2018**

### **Case Summary**

Lancashire LSAB commissioned a Safeguarding Adult Review (SAR) regarding Adult D, who died of natural causes; with diabetes as a significant contributory factor. The full report is published on the Lancashire Safeguarding Adult Board's website [here](#).

Adult D lived with her partner who she had known for 25 years. The couple lived together in a privately rented house with a large number of pets, mostly cats. Adult D's partner acted as Adult D's carer for a long period of her later life but this carer relationship was not widely known to services. Adult D herself was independent despite significant health issues and was assessed as having mental capacity to make decisions around her care needs. A carers' assessment was completed 7 months prior to Adult D's death however this did not consider Adult D's history, the mental health issues and lifestyle of her partner and other possible risks relating to him.

Agencies had infrequent access to the couple's home but those who did observed the home as being "horrendous; rubbish and clutter everywhere". This led to the animals being removed by the RSPCA who referred their concerns about the property to adult social care. Some professionals involved with Adult D suspected possible self-neglect and the police, who were required to attend the address for other reasons, assessed some vulnerability for Adult D and the partner.

On the day of Adult D's death, Lancashire Constabulary attended the home and observed piles of litter and rubbish, rooms were piled high with possessions, with little room to walk. Initially, Adult D's partner was arrested for suspected involvement in the death. Unfortunately due to the estranged nature of Adult D's relationship with her own family they were not aware of the death until many weeks later, and then only by chance.

### **The review highlighted key themes which are listed below:**

- Professionals should identify self-neglect and/or hoarding at the earliest opportunity to enable strategies be put in place to improve outcomes.
- If attending a property and self-neglect and/or hoarding are evident, professionals should identify individuals with care and support needs as possibly meeting the adult safeguarding criteria. Furthermore, a co-ordinated multi-agency response should be considered.
- When undertaking carers' assessments, professionals should always seek to include the individual's history, potential health concerns of the carer and any other possible risks. Additionally, where appropriate, other agencies should be included to enable a more robust assessment e.g. GP.
- Professional curiosity should always be utilised if an individual identifies themselves as a carer and it is clear that their own needs could impact on the ability to provide care. Professional inquisitiveness supports integrated working and where necessary, can lead to assessments being arranged for carers to ensure that they are not placing themselves/and or the cared for person at risk.
- If identified as a carer, professionals should ensure the carer status is recorded as this could inform other professionals with access (if available) to shared recording systems and encourage further enquiry about the carer/cared for relationship.
- Information should always be shared with partner agencies, and within agencies when there are key safeguarding concerns and vulnerabilities such as self-neglect and hoarding have been identified.
- Professionals should always recognise the need to be inquisitive about family circumstances and investigate the useful information that close relatives may be able to provide.

### **Good Practice Highlighted:**

- The concern, confidence and tenacity of the RSPCA officer who reported observations made at Adult D's home of possible self-neglect when attending a report of possible cruelty to animals within the property, and during subsequent visits demonstrated good practice;
- The caring and concerned nature of the housing officer who, after initial involvement with the social worker regarding the RSPCA concerns, made an unplanned, unannounced courtesy call to visit Adult D's home and then raised concerns with the landlord which showed good practice. The officer also attempted to signpost the couple to other local support;
- The awareness of adult safeguarding processes of the ambulance crew and their ability to engage the couple led to a carer's assessment referral being made.