Safeguarding Adults
NORTH EAST LINCOLNSHIRE

1 AD was a young adult male who at the time of his death lived with his mum and step-dad, who had their own mental health difficulties. AD was known to health and social care since he was a child, however as he got older he became less visible to professionals. As a child he was exposed to domestic abuse and neglect perpetrated by his mum. AD remained in his mum's care for much of his childhood.

2 AD died in the hospital, following his arrival by ambulance. AD was found at his home in a poor state, with reports of him being covered in dry faeces, sores, a "crater" on his sacrum and suffering with head lice.

3 AD cause of death was recorded. It is however noted the coroner had not been made aware of all the facts surrounding AD's condition.

AD's case was raised by a whistle blower who was concerned about AD's circumstances.

4 AD circumstances as both a child and adult were complex, yet there was no joint working between agencies to assist with AD's transition from a child to an adult. No one agency had a full picture of his life or fully understood his needs.

5 Following AD's death, it was noted AD did not 'have a voice' during times of professional intervention. It was seen that as both a child and adult AD's mum and step-dad would cancel appointments on AD's behalf and frequently be present during appointments. AD did not lack mental capacity, yet it seemed he had little autonomy in life and was isolated from professionals.

6 Whilst there is evidence of some professionals being persistent and engaging with AD, there are many examples of professionals not exercising professional curiosity or challenging AD's mum or step-dad. Despite AD's age and capacity, the majority of professionals did not seek to speak to AD by himself during appointments. Equally, when appointments were consistently cancelled by AD's mum and step-dad, professionals did not try to speak with AD about this. There are also worries relating to an absence of medication reviews and how periods of non-engagement were managed / assessed.

7 At the time of certifying AD's death professionals may not have recognised the elements of neglect / self-neglect that were present in AD's life. The sudden unexpected death of a young person should always trigger consideration of a referral for a Safeguarding Adults Review.

Throughout AD's life, up the point of his death, there was a lack of professional curiosity when it came to understanding and supporting AD, and many interactions were led by other family members. In hindsight, mechanisms of controlling behaviour by other family members influenced interventions provided to AD; All professionals should recognise that domestic abuse can present in many was and apply to many relationships, not just intimate partners. The Domestic Abuse Act will provide a statutory definition of Domestic Abuse which outlines the scope of such abuse. Updates regarding this can be found here: https://domesticabusecommissioner.uk/news/.

The regular practice of obtaining patients views directly from the patient and not solely relying on reports from carers/other family members, alongside professionals having awareness of patients mental capacity and understanding the reasons for a patients visibility / invisibility to services, are all ways in which vulnerable individuals can be safeguarded from abuse.