Helen Safeguarding Adult Review – Learning summary

Helen lived at home with her husband, who was also her carer. Helen had two grown sons. Helen had physical health issues and misused alcohol. In 2021 Helen's health deteriorated requiring multiple call outs for ambulance services and 3 hospital admissions. Helen's sons raised a safeguarding concern three times over a period of 5 months to hospital staff and to Hampshire County Council contact centre. These concerns related to self-neglect and suspicion of abuse and neglect by Helen's husband. No Section 42 safeguarding enquiry was opened. Sadly, Helen died in hospital in 2021 caused by malnutrition and other health conditions. The HSAB were concerned that joint working across agencies was not adequately utilised and commissioned a Mandatory Safeguarding Adult Review.

What is a Safeguarding Adult Review?
Care Act 2014 Section 44

HAMPSHIRE SAFEGUARDING ADULTS BOARD

Key findings

Barriers to effective communication of safeguarding concerns

Information sharing across several agencies was very limited. Although social care, the hospital and the ambulance service all had part of the picture, the usual mechanisms that support multiagency information sharing and shared risk assessment were not used. This had an impact on how far it was possible to build a more complete picture of risk.

Risk Assessment and making safeguarding personal

Misplaced assumptions by practitioners at Adults Health and Care contact centre about how hospital teams operated in relation to safeguarding concerns contributed to a lack of response in Helens case. The contact centre and multiagency safeguarding hub were managing high volumes of urgent work and needing to prioritise the most pressing cases over others.

Barriers to members of the public being heard

A member of the public should not need to make multiple attempts to raise a safeguarding concern. Practitioners in this case did not have a shared understanding of the 4LSAB Safeguarding Concerns Guidance.

Lack of professional curiosity and hidden harms

The impacts of self-neglect and of coercion and control within a situation are not always easy to detect. Victims of Domestic Abuse may not be easily able to talk about their situation. The opportunity for more in-depth discussions with Helen could have been better supported using the Section 42 framework.

Questions to Hampshire Safeguarding Adults Board

Questions presented to consider how the learning can result in positive action and change within the local safeguarding system in Hampshire. Agencies will work together to develop an action plan to address learning.

- How can the board be assured about the effectiveness of referral pathways and the use of information sharing agreements and duties in relation to risk information?
- How can the board gain assurance that new MASH arrangements are in place and working well?
- How can the board be assured that improvements are being made to improve the response to safeguarding concerns being raised by family or friends?
- How can the board be assured that all agencies understand and are following the 4LSAB Safeguarding Concerns Guidance?

- The recent Self Neglect thematic SAR has highlighted the importance of using 'windows of opportunity' such as hospital stays for social workers to have a conversation with adults who are reluctant to engage with services but may be at risk of self-neglect. How can the board be assured this kind of approach will be developed?
- Is the board assured that post pandemic service delivery in the community is capable of identifying hidden harms?