

Safeguarding Adult Review

Learning Brief – 'Jessica'

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BLACKPOOL SAFEGUARDING ADULTS BOARD

This learning brief is written for publication in line with statutory guidance. To preserve anonymity, the author has changed the names of the subjects of the review.

Case Summary

Jessica was born with Down's Syndrome. As Jessica developed, her level of independence was established; she was independently mobile but required someone with her to access the community. Jessica lacked capacity for many of her decisions but was able to make basic choices when offered options from things she knew and had experience of. Jessica was dependent on others for her meals and the provision of a clean and tidy home environment.

Jessica lived with her mother (Ann) and siblings. When Jessica was 18 years old, Ann moved Jessica from East Sussex to Leeds. In 2016 when Jessica was 21 years old, the family moved to the Blackpool area.

Jessica died at home, aged 24 years as a result of severe emaciation and neglect and widespread and severe scabies infection. There was no evidence of Jessica's hygiene or personal needs having been met for a considerable length of time. Following Lancashire Constabulary commencing a criminal investigation, Jessica's mother pleaded guilty to gross negligence manslaughter and was sentenced to 9 years and 7 months imprisonment.

The focus of the Safeguarding Adult Review was the circumstances surrounding Jessica's deterioration and death.

The review highlighted several key themes and areas of learning which are explained below. A copy of the Safeguarding Adult Review report will be made available on the [LSAB website](#).

Key Themes and Learning Points

Transference of Information Across Borders – when Jessica and her mother announced they were moving to Blackpool, professionals asked Ann whether she would like a referral into Blackpool to be made on Jessica's behalf. Ann declined. It remains unclear why it is recorded that Ann's permission was being sought for a referral to be made. The referral was for Jessica who was an adult, thus it was her permission that was required. If assessment had concluded that Jessica did not have the capacity to make this decision, then a decision should have been made in Jessica's best interest.

It is recognised that the omission of a referral into Blackpool increased Jessica's vulnerability and there were missed occasions when Blackpool, having learned of Jessica residing in their area and having care and support needs, could have contacted agencies/professionals in the areas where Jessica had previously lived for information.

Referrals – In 2017 police alerted the Multi Agency Safeguarding Hub to Jessica, by means of a safeguarding alert, following an encounter with her during which her vulnerabilities were recognised. In the absence of a telephone number, Adult Social Care sent a letter to Jessica asking her to contact the duty Social Worker and discuss the referral and any assessment further. It is very unlikely that Jessica would have understood the letter or been able to follow its direction. Better practice would have been to address the concern directly with Jessica which, given her learning disabilities, would have required a face-to-face meeting.

There were missed opportunities for the GP Practice to make a safeguarding referral regarding Jessica when Ann failed to respond to letters requesting contact be made with the dermatology department to book an appointment, and voicemails from the GP Practice were not responded to. Given the severity of Jessica's skin complaint, it was reasonable to conclude that Ann's failure to address the medical issue on Jessica's behalf necessitated consideration of a safeguarding concern.

Children's Social Care having been made aware of a family members' concerns for Jessica's presentation, referred to Adult Social Care. Although Children's Social Care did initially contact Adult Social Care to ask what action had been taken, this was prior to entry being had by a Social Worker to the home address. No further conversations were had between Adult and Children's Social Care and no professional multi agency meetings were convened.

Whole Family Approach - Jessica's family had complex care and support needs and as such professionals from multiple agencies were entering the home to support other family members who lived there. All professionals entering a home to see any service user must remember to take a holistic view of the whole family and always consider wider vulnerabilities of other family members, particularly when neglect within the family home is an issue. Consideration must be given to sharing information and concerns with appropriate safeguarding agencies, such as Adult Social Care. If consent is an issue, consideration should be given to overriding consent when there is a threat of serious harm or death through neglect or abuse.

Importantly this whole family approach is not limited to statutory organisations.

Carer's Abuse – Given that vulnerable adults who have a learning disability tend to be amongst the most common victims of abuse, any professionals entering the home of an adult at risk, even if they are there to visit another family member, must maintain a professional curiosity and always explore what is happening for the whole household. This requires professionals to use proactive questioning and challenge, and to not take anything at face value.

Multi-agency meetings must be considered, and convened, as appropriate to share as much information and professional curiosity as possible in order to identify safeguarding concerns at the earliest opportunity, and to drive best decision making.

Jessica's Voice - This review has found that in the main, instead of finding a way to communicate directly with Jessica, professionals relied on Ann to speak on her behalf. Ann denies that she deliberately spoke for Jessica and has told this review that she always allowed Jessica to make her own decisions and that she would only repeat what Jessica had told her.

Professionals needed to communicate with Jessica alone and consider her decision-making capacity. It is important that parent carers know that they can no longer make decisions on their adult children's behalf – even when their adult child does not have the capacity to make the decision themselves.

Representation of Jessica's voice in her healthcare was particularly crucial as Jessica, with her learning disabilities, would have experienced poor physical and mental health when compared with the general population. And her communication difficulties would have made it difficult for her to describe any symptoms. There is teaching on 'three-way' or triadic consultation where there is a parent with a child, but that teaching is not always being applied to vulnerable adults accompanied by a family member.

Jessica's voice was inaccurately represented when she was not presented for health appointments as her records showed that she 'Did Not Attend.' Yet Jessica lacked the physical ability and/or mental capacity to attend, or make the decision to attend, appointments. A more accurate description of Jessica not being present for appointments would be to record that she 'Was Not Brought.'

GP Safeguarding – Agencies outside of the GP Practice have a limited understanding of GP system and practice. GPs must be, wholly transparent about all the safeguarding practice they use to support and protect vulnerable people.