# Adult P Safeguarding Adult Review Briefing

## The Background

Adult P had been living in Southampton for many years. For much of that time Adult P was homeless and living on the streets. At the time of her death she was living in a flat owned by a private landlord and supported by carers. The Homeless Prevention Team, community health professionals and social services worked extensively with Adult P over many years around her being homeless in the main. Other risks and vulnerabilities included a tendency for her to self neglect and at times not engage to receive help.

One of the biggest vulnerabilities Adult P posed was that she was alcohol dependent. This dependency had developed in earlier years and she experienced physical impacts of this including incontinence, convulsions, falls, gastric problems, poor diet and vitamin and other blood deficiencies. It is unclear what impact her chronic alcoholism had on her cognitive ability. However over a period of time concerns were raised that Adult P may be developing brain damage from her longstanding and excessive alcohol consumption.

## Safeguarding Concerns

Adult P was known to services and had a history of alcohol dependency which impacted upon her health and wellbeing. Adult P spent a great deal of time homeless and had a substantial history of self neglect. There was also some concern around financial and sexual exploitation by others toward Adult P. The professional response was always framed in the context of professionals' judgement that Adult P had mental capacity to make decisions no matter how unwise. Adult P's self neglect was recorded as persistent in the context of alcohol dependency, depression and obvious physical ill health.

## The Incident

Adult P had been admitted to hospital as an emergency admission in April 2014 with severe injuries following an assault upon her at her flat. Despite medical intervention and significant surgery she died on 20th April 2014. The suspected perpetrator was arrested and subsequently convicted for her murder.

## The Review

This case was selected to be reviewed in that the death met the statutory Safeguarding Adult Review criteria. An Independent Chair was appointed by the LSAB to facilitate and lead the review.

## The Findings

**Findings 1** - Adult safeguarding system - there was no form of statutory or other formal safeguarding process for Adult P. This left single agencies to manage a complex case.

**Finding 2 -** This case reflects the national context at the time of a lack of full understanding of self neglect and associated risks this poses to the adult at risk.

**Finding 3 -** This case demonstrates an over reliance upon the assumption of mental capacity and the limits of understanding mental capacity in more complex cases. This includes where mental capacity may fluctuate. This impacts upon the professional's assessment of risk and what legal framework may be available to protect the individual.

**Finding 4 -** Agencies working with those who present as change resistant drinkers can usefully familiarise with national strategies to manage this. Commissioners of services should have recourse to the national strategies to plan services accordingly.

## Useful links for good practice

- 4LSAB Safeguarding Adults Multiagency Guidance, Policy and Toolkit
- 4LSAB Risk Management Framework
- 4LSAB Guidance on Responding to Self Neglect and Persistent Welfare Concerns
- Southampton LSAB Risk Assessment and Management Guidance
- Guide to Mental Health Services in Southampton
- Southampton LSAB website
- Alcohol Concern Blue Light Project - Working with change resistant drinkers
- SCIE Self Neglect - At a glance
- NICE Guidance – Decision Making and Mental Capacity
- SCIE Safeguarding Adults and Housing Staff guide