The subject of this learning review was a young man who died at age 29. At the point of death he was extremely underweight, had a documented alcohol addiction and was self-neglecting. The HSAB felt that although the case didn’t meet the criteria for a safeguarding adult review there was evidence of good practice which could be explored and shared plus the opportunity to identify areas for improvement.

Pen Picture

X was a young man with a learning disability who over a period of years suffered with an alcohol addiction. This resulted in self-neglect to a point where he could no longer go upstairs and slept on a sofa downstairs. There was also previous domestic abuse within the family.

A Safeguarding concern was raised by the District Nursing team and they liaised closely with the social care worker and chair of the Safeguarding meeting prior to a hospital admission.

On admission the patient was found to weigh only approx. 35kg, there was evidence of self-neglect, reduced mobility, multiple pressure ulcers and he had been suffering from a flu like illness for previous 3 days.

A couple of days after admission he was transferred to Intensive Care Unit, where he deteriorated over night and died.
Examples of Good Practice

There had been a lot of agencies involved in the case and they had all worked really hard to support X.

The agencies had been talking to each other. The agencies had cooperated with each other to gain access to X.

Both Social Care and HPFT kept trying to engage with the family over a long period of time and kept cases open to try to encourage engagement.

There was documented persistence of an Occupational Therapist (HCT) to arrange appointments despite the difficulties in contacting the family. The case had not been closed due to no contact.

Once the OT (from Hertfordshire Community Trust) had made contact with the family they took other health professionals along with them to ensure access to the family.

Learnings and Resources

A Multidisciplinary Team meeting could have been held earlier and the family could have been involved in the meeting.

The larger family dynamics could possibly have been addressed differently.

Better co-ordination between agencies could have saved time and resources.

There was no clear lead agency.

What has the HSAB done?

There is now a HSAB multi-agency complex case guide for professionals, which gives advice and guidance on using multi-agency meetings to manage cases.

This guide also helps identify a lead professional and gives a clear template for running a multi-agency meeting.

The HSAB has also issued a comprehensive guide to managing self-neglect cases.

Both these guides will be reviewed to ensure family dynamics are reviewed by professionals.


If you require further information on this bulletin please contact Mary Moroney, Safeguarding Boards Manager, mary.moroney@hertfordshire.gov.uk