7. Further Information and resources

- ❑ The importance of professional curiosity in safeguarding adults | Research in Practice
- ❑ Working with carers of adults with mental health needs: quick guide - Adults (ccinform.co.uk) (For ASC staff only)

6. Recommendations

- ❑ Safeguarding Partnership seeks assurances that individual Agencies who identified their own learning, recommendations and actions have completed these.
- ❑ AQ's lived experience to be reflected within Young Carers training to staff.
- ❑ Professional curiosity is embedded within training.
- ❑ 7 min briefing to be shared at staff Forums.

5. Key Learning from ASC

- ❑ Covid 19 restrictions resulted in reduced face to face contact with AQ. Evidence suggests she was not seen face-to-face in 32 months.
- ❑ No consideration of AQ's son as a young carer for his mother.
- ❑ Care reviews were not meaningful as they lacked professional curiosity resulting in a lack of triangulation of information.
- ❑ When information was provided by other agencies evidence suggests AQ had an issue with alcohol and struggled to maintain the home environment and her personal care when she was unwell. This information could not be located within ASC records.
- ❑ Children's Services were not contacted, or information shared about whether son's needs were being met or to raise concerns.

1. Background

- ❑ AQ was diagnosed with bi-polar, anxiety and alcohol issues. She lived alone with her 15-year-old son who had Autism Spectrum Disorder and additional needs.
- ❑ AQ was known to Adult Social Care (ASC); Mental Health Services; GP; Education; and Children's Services (CS).
- ❑ The Disabled Children's team had been involved previously but there had been no current contact.
- ❑ AQ had a small care package provided by direct payments which included support for her son to access the community.
- ❑ AQ was found deceased at the family home by her son on the 01/09/2022. When emergency services arrived at the property concerns were raised regarding poor conditions in the property caused by self-neglect. In addition, concerns were raised about the neglect of her son.

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2. Concerns

- ❑ Risks identified within ASC records included the following:
  - Neglect
  - Severe social isolation
  - Severe and persistent distress/critical deterioration in mental health and wellbeing
  - Breakdown in caring relationship between parent and child.
  - Risk of decline to physical and mental wellbeing if not compliant with prescribed medication.

4. Key Learning from other agencies

- ❑ Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) – a serious incident investigation identified safeguarding concerns not raised in relation to her son.
- ❑ Integrated Care Board (ICB)– Lack of professional curiosity. Family were hidden in plain sight.
- ❑ Education – Lack of professional curiosity, professional challenge.
- ❑ CS – limited involvement prior to 2017. School did raise concerns in 2018, however no evidence to suggest contact was made with AQ.

3. Key Themes from the Lessons Learnt

- ❑ Needs of the Young Carer not assessed or considered.
- ❑ Lack of face-to-face contact
- ❑ Lack of MDT working - triangulation of information between agencies not carried out.
- ❑ Safeguarding Adults Policies and Procedures not followed
- ❑ Lack of professional curiosity and professional challenge