Learning Brief

Safeguarding Adult Review & Domestic Homicide Review Case Consideration for Alex

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BLACKPOOL SAFEGUARDING ADULTS BOARD

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Background

Alex was 44 year-old women who lived with significant health and mobility challenges linked to morbid obesity. She died in hospital from sepsis, lobar pneumonia, cellulitis and a urinary tract infection, with morbid obesity as a contributing factor. Alex's death was referred for a Safeguarding Adult Review due to concerns about the living environment and family circumstances. Alex lived with her husband and three young children in extremely poor conditions, with clear signs of self-neglect, hoarding and child neglect. Two adult children, living elsewhere, had raised concerns that Alex was being neglected by her husband.

Due to the complex circumstances, and multiple concerns, the Chairs for Safeguarding Adult Review (SAR), Domestic Homicide Review (DHR) and Child Safeguarding Practice Review (CSPR) processes reviewed the information and agreed a SAR was the most appropriate route for consideration. The DHR criteria was reconsidered at a later point and a DHR consideration meeting was held in November 2025.

Several agencies had been involved with the family over a number of years. Adult Social Care had previously supported Alex with a detailed care plan and mobility aids, but this ended in 2016 at Alex's request. Children's Services had implemented a Child Protection Plan the same year due to poor home conditions, with Early Help continuing support afterwards until the family declined support. Further concerns were raised in 2023, but the family did not consent to Early Help. When Children's Services were notified of Alex's death in 2024, the home was found in extremely poor condition, leading to the children being safeguarded to alternative care.

The family lived in a home provided by a housing association. The housing provider attempted to visit the property on multiple occasions to undertake the gas safety check during 2024, but was unable to gain access, and received no reply to follow up correspondence. The provider reported that no concerns regarding the external state of the property had been raised by neighbours or other professionals.

In the months prior to her death, Alex had several telephone consultations and email correspondence with her GP Practice to request medication to treat suspected cellulitis. Medication was provided based on the information given and photos provided. Alex was offered face-to-face consultations but declined due to mobility challenges and feeling unwell. In the days prior to her death, the GP referred Alex to the district nurses who attempted to arrange home visits; however this was not achieved prior to Alex being admitted to hospital where she sadly died.

What have we learned?

The SAR and DHR consideration panels reviewed information from all agencies that worked with Alex and her family and, as there was no evidence to suggest that agencies had failed to work together, the panel agreed that the criteria for review had not been met. There was however some areas for learning and impact on practice, in the event of similar or identical incidents occurring in the future.

Self-neglect, environmental risk and deteriorating conditions: Self-neglect can escalate rapidly, particularly when deterioration is hidden from professionals or when contact with services is mainly remote. Without direct access to the home, agencies were unable to fully understand the extent of environmental risks, hoarding behaviours, or neglect that were developing.

Although opportunities to engage face-to-face were limited, there were some occasions where agencies attended the family home in concern of the children. This was identified as a potential missed opportunity to identify concerns around the health and wellbeing of Alex and recognise that self-neglecting behaviours were present. Had such concerns been identified, a safeguarding concern may have been raised with Adult Social Care.

Professional curiosity was inconsistent across agencies. Changes in Alex's health, mobility and day-to-day functioning were not fully explored, and decisions to decline support were often accepted at face value without considering capacity, executive functioning, or whether Alex had the practical ability to engage. There were periods where Alex appeared to be managing, and multiple opportunities for face-to-face contact were declined. Disguised compliance may have been a feature, and more persistent professional curiosity and trauma-informed approaches could have helped practitioners understand the reasons behind non-engagement.

There was no evidence that Alex's mental capacity in relation to her health or living environment had been assessed. Practitioners should consider whether a capacity assessment is required when an individual's ability to make or act on decisions may be impaired. Where a person is assessed as having capacity, their right to make unwise decisions should be respected, while still balancing the need to safeguard their wellbeing and the safety of others in the household.

Identification of carers: There was a missed opportunity to identify Alex's husband as a carer and to consider whether a statutory carer's assessment was required. In addition, he was not always actively included in assessments as a father/male carer, despite the involvement and influence he may have had on the wider situation. A clearer understanding of caring roles, and consistent engagement with all key adults within the household, could have strengthened the multi-agency response.

Multi-agency coordination and information sharing: Information about environmental concerns and increasing risks was held across different agencies but was not consistently shared or escalated, which limited the wider understanding of the situation. Although education and Early Help recognised emerging concerns, consent barriers sometimes delayed appropriate escalation. In addition, multi-agency pathways did not always align, resulting in missed opportunities for joint decision-making and coordinated action.

The review highlighted a need for clearer multi-agency understanding of the statutory tools and powers available to support safe access to a home. In this case, greater awareness of tools such as housing enforcement may have enabled earlier joint action and a more coordinated response.

Think Family and whole-household safeguarding: Adult needs, children's needs and environmental risks were closely interconnected. While elements of a Think Family approach were evident, this was not consistently embedded across all services. Although children's voices were heard within education settings, this insight did not always lead to wider multi-agency action or a coordinated response to the increasing concerns within the household.

A Think Family approach requires practitioners to consider how challenges affect all members of the household and to look beyond the primary individual receiving support, whether this is an adult or a child. This includes recognising the needs of other potentially vulnerable adults, as well as identifying anyone undertaking a caring role – formally, informally, or as a young carer – and ensuring carer assessments are offered where appropriate.

It also involves actively involving fathers and male carers in assessment and planning, ensuring their role, influence, and support needs are fully understood. Strengthening whole-household practice would have supported a more coordinated and holistic response to the family's needs.

Bariatric care needs: Alex was morbidly obese and appeared not to have left the home environment for some time, despite requiring medical assistance. Support from the Fire Service was needed to transport Alex to hospital for treatment prior to her death. Additional support for bariatric care needs requires exploration to ensure appropriate pathways are available and clearly understood by practitioners at the earliest opportunity.

Good Practice

Across the review, several examples of good practice were identified, and it is important to recognise these strengths, as part of the consideration process. Education settings responded promptly to emerging concerns, ensured children's voices were heard, and escalated when worries increased. District nursing and primary care teams made repeated attempts to engage with the family and appropriately escalated non-engagement.

Professionals across agencies showed notable persistence in maintaining involvement despite significant barriers, and hospital staff and police acted appropriately by raising immediate safeguarding concerns that resulted in the children being protected without delay. These examples highlight the commitment of practitioners and the positive practice as part of the multi-agency response.

What do I need to do?

Be professionally curious: explore what may be happening for the individual or family, particularly when support is declined. Look, Listen, Ask, and Clarify if you're unsure of anything. Ensure professional judgements are clearly documented, including the rationale for decision-making.

Face-to-face engagement and assessment of risk: complete home visits where self-neglect, hoarding, poor conditions, or functional decline may be present. Where there are barriers to engagement, consider the tools and statutory powers held by partner agencies that may support access to the home environment and enable a thorough assessment of risk. Escalate repeated non-engagement as a safeguarding concern and take action through safeguarding pathways where risk remains.

Think Family and Whole-household: consider all adults, children, carers and the wider 'family network'. Who else is present, how are they being impacted, and does anyone require support from other agencies?

Understand self-neglect: recognise the signs of self-neglecting behaviours and know how to respond to support the individual, and anyone else affected. The Multi-agency Guidance for Responding to Self-Neglect can help you with this.

Consider children who may be affected: If an adult's self-neglect is impacting children, or placing them at risk of harm, recognise the signs of child neglect and consider making a Request for Support. Use the Blackpool Safeguarding Children - Neglect Strategy for Children, Young People and Families and the Graded Care Profile 2 toolkit to inform your assessment.

Consider carers: identify and support all carers – including young carers – by recognising caring roles within the household, offering statutory carer's assessments where appropriate, and ensuring fathers and male carers are routinely engaged in assessment and planning.

Keep in touch

- For queries or feedback, please contact the Blackpool Safeguarding Partnership's Business Unit: BSAB@blackpool.gov.uk
- Visit the Blackpool Safeguarding Partnerships website for training, information and resources.