‘DANNY’ LEARNING BRIEFING
OCTOBER 2025

Isle of Wight Safeguarding Adults Board

OVERVIEW

Following the death of Danny in September 2024, a referral was made the to the Isle of Wight Safeguarding Adult Board for consideration under its statutory duty to undertake a Safeguarding Adult Review.

Following a full review of the information available from partner agencies, it was agreed that the case did not meet the criteria for a formal safeguarding review under the Care Act legislation. However, it was felt that there may be an opportunity for focused learning.

In February 2025, key agencies met to identify the events leading up to Danny’s death, the workshop focused on multi-agency interactions with both Danny and his mother in the years leading up his death. The workshop highlighted issues related to case management, multi-agency collaboration, record keeping and those who are hard to engage.

SUMMARY OF THE CASE

Danny lived with his mother in the family home since moving to the Island when he has 19. Danny was described as well-mannered, intelligent and charming, who enjoyed watching quiz shows and playing computer games. Danny had a diagnosis of Marfan Syndrome, depression, and was a functioning alcoholic. Danny secured the occasional temporary job but was not in receipt of any benefits in the years preceding his death and lived off an allowance given to him by his mother. Danny didn’t have any significant relationships in his life, leading an almost reclusive life with his mother as his main companion.

Between 2015 and 2018, the family were supported by Officers from the Local Authority and a Housing Association in respect of the condition of their family home. In 2018 a Repair and Wellbeing Grant was awarded, and work was completed to make the property structurally safe and sanitary.

Danny’s mother was taken ill in June 2022 and following an admission to St Marys Hospital, was moved into a nursing home, regularly expressing her wish to return home. Colleagues from Adult Social Care were concerned for her safety should she return to the property due to its condition and despite attempts to contact Danny in order to facilitate her return, he did not engage, and his mother remained a resident of the nursing home.

Historically, Danny did not engage with any service and relied on his mother as his advocate, particularly around his health needs. However, following her admission to hospital, Danny ‘dropped off the radar’ and was not keeping on top of his medication and wider health needs.

During her stay in the nursing home, Danny would regularly visit his mother, however on 2 occasions, she raised ‘concern for welfare’ reports with the Police as she had not seen or heard from him, both times the Police located Danny but did not enter the family home.

Danny spoke to his mother on the 22nd August 2024 but by the beginning of September, Danny's mother once again, grew concerned that she hadn't heard from him and had a feeling that something was wrong. Following contact with the Police, Officers attended the family home and found the property to be in significant disrepair and clutter which was consistent with hoarding.

Sadly, Danny was found deceased.

KEY FINDINGS:

- Following considerable financial support and property maintenance there was no ongoing support offered to the household.
- The Police conducted two 'safe and well checks' and spoke to Danny, however, they had no record of him being a vulnerable adult. The Police did not enter the property and had no cause to complete a PPN1.
- It's unclear whether a referral to the local fire & rescue service was made in respect of a Safe and Well visit, the significant hoarding and condition of the property were a fire risk and would warrant a referral.
- There was a lack of referrals to the local authority safeguarding team in respect of Danny or his mother.
- Adult Social Care added Danny to a 'hoarding' list. This work was led by a single practitioner and became part of the ILS (integrated Locality Services).
- Danny was not considered a vulnerable person by primary care services and therefore his lack of engagement did not raise any concerns.
- Danny was not seen as an individual with care and support needs in his own right.
- There is no evidence that agencies considered the 4LSAB Family Approach guidance
- There is no evidence that the Multi-Agency Risk Management framework was considered or applied.
- Communication with Danny was limited and when contacted to discuss his mother's return home, practitioners did not consider that his agreement was not required, this caused prolonged delays, case drift and was not in line with legal frameworks.
- Despite being referred to the Integrated Locality Service, there are no records of the outcome of any discussions and the actions taken to reduce risk.
- There appears to be a lack of knowledge of the Integrated Locality Service, its referral route and the role it can play in supporting residents.
- The Integrated Locality Services appear to have a gap in knowledge of the Multi-Agency Risk Management (MARM) framework and how this could be utilised.

WHAT THIS MEANS FOR YOU:

☑ **Review** the 4LSAB MARM Guidance to refresh your knowledge on the expectation of undertaking this role.

☑ **Consider** whether individuals with complex lives (e.g. poor mental health, substance misuse and/or Domestic Abuse) should trigger a MARM.

☑ **Refresh** your knowledge of the Integrated Locality Services

☑ **Consider** the needs of those who are hard to engage and review your organisations protocol for identifying and managing vulnerable individuals.

☑ **Refresh** your knowledge of the 4LSAB Family Approach guidance

☑ **Refresh** your knowledge of the 4LSAB Multi-Agency Fire Safety Framework