

OVERVIEW

Following the death of Jill in early 2025, a referral was made to the Isle of Wight Safeguarding Adults Board to consider whether the care and support provided leading up to her death would meet the threshold for a formal safeguarding adult review under the Care Act.

To further understand agencies involvement, a reflective learning workshop was convened and key professionals shared details of their interactions with Jill. Following this workshop, it was agreed that whilst the threshold had not been met, however important learning could still be shared to improve local practice.

SUMMARY OF THE CASE

Jill lived on the Island her whole life and was described by her family as an intelligent and a 'happy go lucky' person. Jill lived with several health issues, including poor eyesight, hearing issues and type 2 diabetes.

Following a period of hospitalisation to provide support to control her diabetes, Jill became distressed at being away from her beloved pets and subsequently became wary of services intervention, shaping her future interactions with services.

During December 2024, Jill's mood deteriorated, and she disengaged from health services, making the management of her diabetes more challenging. Jill's mental capacity was questioned due to concerns regarding her ability to management her health, a warrant under Section 135 of the Mental Health Act was granted by the Courts to remove Jill from her home and take her to a place of safety. Sadly, upon execution of the warrant, Jill was found deceased, she was in her 70's.

KEY FINDINGS:

- Lack of safeguarding referrals from primary care
- Lack of safeguarding meetings or MARM application
- Treatment for physical health was compromised due to concerns over mental capacity
- Lack of communication between professionals
- Legal frameworks were misunderstood (e.g. MCA, MHA)
- Lack of clarity of who 'owned' Jill's case that led to missed actions
- Need to manage diabetes overshadowed by mental capacity assessment
- The 'No Wrong Door' model was not applied, triage assessments hampered escalation
- Professionals were falsely reassured on mental capacity
- Trauma from previous interventions influenced services engagement with services

WHAT THIS MEANS FOR YOU:

- **Act early and decisively** – If you have concerns, don't wait, make a Safeguarding referral to the Local Authority. Consider referring to the Integrated Locality Service or convene a Multi-Agency Risk Management (MARM) meeting. Early collaboration saves lives.
- **Don't let safeguarding drift** – If you've made a referral, follow it up. Ensure it's been received, understood, and acted upon.
- **Raise your voice** – If something doesn't feel right, escalate it. Use the 4LSAB Escalation Protocol to challenge decisions or inaction.
- **Sharpen your legal literacy** – Revisit the Mental Capacity Act (2005) and ensure you're applying the right legal framework to your decisions. Misunderstanding the law can delay or derail vital care.
- **Own your part** – Know your role in the system. Don't assume someone else is leading. Take responsibility for coordinating or clarifying next steps.
- **Be trauma-informed** – Recognise how past experiences may shape a person's engagement with services. Adapt your approach with empathy and persistence

LINKS FOR BEST PRACTICE AND FURTHER LEARNING

[4LSAB Multi-Agency Escalation Protocol](#)

[4LSAB Multi-Agency Risk Management Framework \(MARM\)](#)

[Mental Capacity Act Toolkit](#)

[7-minute briefing – Mental Capacity Act](#)

[Diabetes Group Isle of Wight](#)

[1-minute guide to Self-Neglect](#)

[IW Integrated Localities](#)

[4LSAB Family Approach](#)