



Derby Safeguarding Adults Board

Learning Brief for Practitioners

Safeguarding Adults Review: Pink

July 2025

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A Safeguarding Adults Review (SAR) is a legal duty under the Care Act (2014), which states that the Safeguarding Adults Board must arrange for a review of a case involving:

- a) an adult in its area with care and support needs (whether the local authority was meeting any of those needs)
- b) if there is reasonable concern about how the Board, or members of it or other persons with relevant functions worked together to safeguard the adult and
- c) the Safeguarding Adults Board knows or suspects the adult has experienced serious abuse or neglect and there is concern how the partner agencies have worked together to protect the individual.

In 2024, the Derby Safeguarding Adults Board (DSAB) commissioned a Safeguarding Adults Review (SAR) following the death of Pink (a pseudonym), an adult with care and support needs. DSAB agreed that the review would focus on the 12-month period leading up to Pink's death, with the exception that agencies could provide additional information on significant events or activities from earlier years if relevant.

An Independent Reviewer led the SAR and completed the final report, drawing on information provided by partner agencies that had been involved with Pink. A Practitioners Learning Event was held, bringing together representatives from all key agencies involved in Pink's care and support.

The main objectives of the event were to:

- Reflect on what worked well,
- Identify what could have been done differently, and
- Develop recommendations for improvement.

The event focused on significant events and key themes identified within the SAR timeline.

A SAR Panel was formed, made up of senior managers from lead agencies who had no prior involvement in the case. These individuals were chosen for their professional expertise and their ability to drive change within their respective organisations.

The final SAR report and its recommendations were formally approved by DSAB in July 2025.

Background

At the time of her death, Pink was 30 years old. She was described as a happy and sociable individual who "knew her own mind" and had clear preferences. Pink used a communication aid at the day centre and during school, which she also enjoyed playing games on and often won when playing against her mother. Pink had a positive relationship with her siblings and wider family.

Pink had a diagnosis of athetoid cerebral palsy and was considered by professionals to have profound and multiple learning disabilities. These, along with other physical disabilities, significantly impacted her ability to communicate and live independently. Pink was unable to sit unaided and relied on a custom-made modular seating system within a wheelchair to support her posture and mobility. Pink required assistance with all aspects of her daily care, including being fed during mealtimes.

Pink lived with her mother and attended a Day Centre from 2012 to 2020, when the Day Centre temporarily closed due to restrictions in response to the coronavirus pandemic. Pink's mother actively contributed to this review. She shared valuable insights into Pink's early life, her skills, preferences, and personality, as well as her own experiences of meeting Pink's needs and engaging with various support services.

During the review period, Pink was known to and had contact with multiple agencies, either directly or through her family.

According to the Coroner's post-mortem report, Pink's cause of death was recorded as airway obstruction due to aspiration of vomit, cerebral palsy, chronic constipation, and malnutrition.

Areas of good practice

1. Staff at the Day Service knew Pink extremely well and were able to engage her in many activities which she enjoyed. Pink's attendance at the Day Service was very good.

2. Staff appropriately raised concerns about Pink's welfare in a timely manner and many Multi-Disciplinary Team meetings were held to discuss issues of neglect.
3. Speech and Language Therapists tried to engage with Pink whilst she was at home.
4. Professionals had good access to Pink at the Day Centre for healthcare monitoring and Pink had access to many and varied professional staff.
5. Pink had an annual health check and appropriate concerns were referred onwards.
6. Professionals were very creative in their attempts to gain access to Pink.
7. Derby and Derbyshire Safeguarding Adults Boards have produced guidance that includes the distinction between Did Not Attend and Was not Brought.
8. People with learning disabilities in Derby and Derbyshire have access to a Rehabilitation Consultant and Complex cases clinic.

Areas that require improvements

1. Pink's views, wishes and preferences were responded to inconsistently and Pink's level of cognition, comprehension and abilities to express herself were not well understood by professionals.
2. Pink was understood to lack mental capacity but processes following from this were not used. The process for making decisions on Pink's behalf and her involvement in this was not recorded.
3. Pink was not observed eating and drinking for a three-year period after she stopped attending the day service.
4. The response to the coronavirus pandemic meant that Pink remained at home without contact with services.
5. There was limited multi-agency identification and management, and risk and escalation processes were not used.

Recommendations

1. All agencies to ensure that when a communication aid is provided by Electronic Assistive Technology Service, it should be available for use in which ever setting the person is in. An alternative method of communication

should also be in place e.g. paper symbols, signing, someone which knows the person well who may be able to support the person's communication as an interim.

2. Derby Safeguarding Adults Board to receive assurance and evidence from all partners that they are working on the ongoing NHS digital flag for reasonable adjustment project.
 - all adults with learning disabilities and accompanying complex physical disabilities have reasonable adjustments made for them, which may include an up-to-date communication passport.
 - reasonable adjustments, and where in place communication passports, have been used in health and social care appointments.
3. Derby Safeguarding Adults Board to receive assurance and evidence from Derby and Derbyshire ICB that, through GP surgeries:
 - promotional materials/events to promote the use of annual health checks and communication passports for adults with learning disabilities have been developed.
 - annual reviews/annual health checks include a question about whether anything within the communication passport has changed, which require a reassessment of an individual's communication skills if present.
4. Derbyshire Healthcare NHS Foundation Trust, Adult Social Care and Derby and Derbyshire ICB to ensure that guidance and/or MCA training includes the need to make decisions in someone's best interests when they have been assessed to be unable to make the decision themselves and to ensure that, where the decision is significant or complex, permanent, contentious and may be open to scrutiny, that the mental capacity assessment (irrespective of the outcome) and any best interests decision making processes are clearly recorded. Training and/or information should include how and when to apply to the Court of Protection.
5. Building on the work that has already been done, health and social care to have the ability to record the number of Was Not Brought appointments and consider actions to take, including raising a safeguarding concern if

appropriate, using the Derbyshire Share Care Records. Derby Safeguarding Adults Board should promote its Was Not Brought Policy across all agencies.

6. Signposting to psychological support to be offered to carers repeatedly (at carers assessments, annual health checks, annual health action plans and reviews) not just practical support.
7. Derby Safeguarding Adults Board should receive assurance from Derbyshire Healthcare NHS Foundation Trust, Adult Social Care and Derby and Derbyshire ICB that the existing processes for raising and sharing concerns about care needs, safeguarding or access are being used by their staff

Next steps

All agencies and professionals are encouraged to reflect on the findings and identified recommendations to improve future practice.

These recommendations will be monitored by the SAR Operational Group who will seek assurances from the agencies named in the above report that these recommendations are being acted upon and will inform and improve practice for the future.