Somerset Safeguarding Adults Board:
PRESS RELEASE
Review recommends improvements following death of Somerset resident

A series of recommendations have been made by the Somerset Safeguarding Adults Board (SSAB) following the death of a Somerset resident.

The recommendations are shared in a report published today (24th June 2025) which documents the situation of Hazel (pseudonym), who lived in her own flat, on a campus style site since she was 15 years old. Hazel was historically diagnosed with a learning disability, autism and bell's (facial) palsy. A significant symptom of Hazel's autism was anxiety, and she was driven to complete tasks and routines which she found comforting.

Instructions were shared with staff to only provide food cut into bite sized pieces, but in July 2019, Hazel received her supper, which included a sandwich cut in half. She was noticed by her allocated one to one support worker to be choking and first aid was commenced, and an ambulance called. The paramedics were able to restart Hazel's heart, and she was transferred to hospital where she was placed on life support. In agreement with her family, Hazel's life support was turned off and she died three days later.

Highlighting improvements that could be made in the way information is recorded and shared across the health and social care system, the report makes various recommendations, including:

- SSAB should obtain assurance from those overseeing provider concerns that the CQC is involved and regularly updated.
- As part of the assurance process, SSAB should gather information on the impact of the CQC's new regulatory regime, including the effects of regulatory inspections and actions on the entire provider business.
- SSAB should ensure the Southwest ADASS Guidance for Out of Area placements is effective and escalate any unresolved compliance issues with distant placing authorities.
- SSAB or an appropriate partner should audit cases with choking risks to ensure the implemented changes are effectively managing these risks.
- The Resolving Professional Differences Guidance should include advice on handling professional differences across regional areas, particularly concerning out of area placement issues.
- Organisations providing direct care to individuals with autism should implement a competency-based training framework. This framework should ensure that staff members with the most frequent contact and care responsibilities receive

specialised training. This requirement could be incorporated into provider service contracts.

- Relevant organisations and staff should undergo comprehensive training on managing dysphagia to ensure they are equipped with the necessary skills and knowledge. This training should cover the identification, assessment, and management of dysphagia, including practical strategies for safe swallowing and nutrition. Regular updates and refresher courses should be provided to keep staff informed about the latest best practices and guidelines.
- Where providers are utilising agency staff to deliver care, they should ensure that they are appropriately trained to deliver safe care, e.g. in this case that they had received dysphagia training
- GPs should consider other health care issues identified by different healthcare professionals when conducting Learning Disability Annual Reviews. This holistic approach ensures comprehensive care and addresses all aspects of the patient's health.
- Significant changes in care, especially regarding long-term medication, should involve the family and include a mental capacity assessment when there are concerns about a person's ability to make decisions for themselves or when there is disagreement about the changes. The Local Learning Disability STOMP Pathway and any other local guidance should be reviewed to ensure that it reflects this. https://nhssomerset.nhs.uk/prescribing-and-medicines-management/prescribing-guidelines-by-clinical-area/neurodivergence/#STOMP
- The SAB should request information from relevant organisations on how senior management and relevant board members are informed about high-risk cases. Additionally, the SAB should seek recommendations and action plans for situations where such processes are not already established within the system.
- Somerset Council and the Somerset ICB should ensure that both policies concerning provider organisations and organisational abuse are aligned with current safeguarding and quality assurance practices. In doing so, they will review the existing system and available guidance
- SSAB with relevant partners should undertake a multi-agency case file audit for individuals affected by organisational abuse and neglect and analyse whether the system has improved over the last five years. Careful consideration as to audit questions must be considered e.g. evidence of use or professional disagreements policy. Actions and recommendations should ensure from the audit.
- SSAB should provide guidance to practitioners on legal literacy, particularly within the MARM process. Consider producing a seven-minute briefing that covers the basics and reminds organizations to use the Legal Literacy Practice Tool as a valuable resource.
- In light of the insights gained from this safeguarding adult review and considering the time elapsed since the introduction of new processes, SSAB should reissue and remind agencies of the following guidance:
  * Resolving professional differences
  * The seven-minute briefing "Reviews of Adults Placed in Care Homes and Specialist Hospitals"
  * Information regarding the importance of advocacy - https://swanadvocacy.org.uk/services/advocacy-services/ and consider a 7 minute briefing an advocacy

- SSAB should ensure that the learning from this review is disseminated as widely and diversely as possible. The Board should provide materials tailored to different audiences and learning styles. Additionally, the Board should ensure that any elements of learning not explicitly covered in the recommendations above are included in the general dissemination of the review's findings.

The learning from the review will be shared with all providers of residential and nursing care operating in Somerset, the Somerset Registered Care Provider Association (RCPA), the Care Quality Commission (CQC), the Local Medical Council, employees of Somerset County Council's Adult Social Care Service, and NHS Somerset Clinical Commissioning Group's Continuing Health Care Team.

Professor Michael Preston-Shoot, Independent Chair of the SSAB said:

> "The Somerset Safeguarding Adults Board exists to protect people at risk of abuse and neglect and to make sure lessons are learned so that necessary improvements can be made. I want to take this opportunity to offer Hazel's family my sincere condolences for their loss.
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> Hazel's tragic story has highlighted that further work is required to sharing information across our organisations to safeguard those with support & care needs and learning disabilities in Somerset. I am pleased to see that the organisations involved were open to these improvements and lessons have been learned with many changes having already been implemented. I will now work with SSAB partners to ensure that this learning becomes normal practice."

The Somerset Safeguarding Adults Board is made up of all the organisations which have a role in preventing the neglect and abuse of adults, including: Somerset Council, Somerset NHA Integrated Care Board, Avon & Somerset Police, Somerset NHS Foundation Trust, National Probation Service, Registered Care Provider Association and Healthwatch Somerset.

For more information about the SSAB and a copy of the report visit www.ssab.safeguardingsomerset.org.uk

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Notes to editors