Rotherham Safeguarding Adult Board

A Safeguarding Adults Review (SAR)

V6

ASSIGNED PSEUDONYM: SAMANTHA

Author: Karen Rees

Presented to Rotherham Safeguarding Adult Board (RSAB) 24th October 2022

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1. INTRODUCTION

1.1. Samantha was a 33yr old female of white British origin who had longstanding mental health illness, diagnosed with paranoid schizophrenia who was found deceased further to Covid symptoms (as reported to the fire service by her mother). It was noted that Samantha had been deceased for several days before she was found. The coroner recorded death by natural causes from an Idiopathic thrombotic pulmonary embolism[1]

1.2. Samantha lived alone in a private rented property – poorly maintained by the landlord, in need of repairs and in a neglected state. Samantha had been noted by services to be dishevelled and struggling to care for herself in the previous months.

1.3. Samantha was known to a range of services who found it difficult to engage with her.

1.4. Police received multiple calls from Samantha with concerns that there were intruders in her property and that she could hear people in the house. None of these incidences were found to be as a result of intruders. It was noted that Samantha had not been taking her medication for management of mental health symptoms for some time.

2. PROCESS, SCOPE, AND REVIEWER FOR THE SAR

2.1. The Terms of Reference, scope and methodology for the SAR can be found in Appendix 1. The review set out to cover a 19-month period prior to the death of Samantha, being the time that concerns were being raised and services were trying to engage her. RSAB commissioned an independent reviewer to chair and author this SAR[2].

2.2. It is of note that two SARs[3],[4] published 6 and 12 months before the start of this review found much of the same learning. Whilst this was not recognised within the original terms of reference, within this review, the intention is to update RSAB on where any new learning has been found, identify progress of previous recommendations, and add any relevant new recommendations.

3. FAMILY INVOLVEMENT IN THE REVIEW

3.1. A key part of undertaking a SAR is to ensure that families are integral to the review process. Families can provide their views and insights that professionals may not have. A more complete picture is often available from families who often provide a unique perspective both of the person and the services received. RSAB wrote to Samantha's mother to inform her of the review and tried on many occasions to make contact. When contact was made, Samantha's mother stated a wish not to be involved. This was followed up by a letter from the author expressing the benefits to the review of seeking her views.

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[1] Idiopathic thrombotic pulmonary embolism; blood clot blocking vessel in lungs of unknown cause

[2] Karen Rees is an Independent Safeguarding Consultant with a nursing background. Karen worked in safeguarding roles in the NHS for a number of years. Karen is completely independent of RSAB and its partner agencies.

[3] 2021 SAR David RSAB https://www.rsab.org.uk/downloads/download/15/safeguarding-adults-review---david?downloadID=15

[4] 2021 SAR The Painter and his Son RSAB https://www.rsab.org.uk/downloads/download/17/safeguarding-adult-review---the-painter-and-his-son?downloadID=17

Further contact will be made when the review finalised and then when it is published. Attempts to contact other family members were not possible as no agency who had been involved had up to date details; further research would have constituted a breach of data protection. The review therefore has been undertaken with no family involvement which may limit some of the learning and only presents agency and service contacts. Factual accuracy regarding the background has not been supported by a conversation with family and is therefore based on what agencies have recorded in their records.

4. BACKGROUND PRIOR TO SCOPING PERIOD

4.1. The reports and information gathered for this SAR provided very little information about Samantha or her younger life. Samantha had a child who was born when Samantha was 28 years old, four years prior to the review period. This did not become apparent at the time of the SAR referral. The GP practice were not aware that Samantha had a child. Information was gathered from children's social care in the locality to provide some background information some of the following information comes from that report.

4.2. As a child, Samantha had several periods subject to child protection plans. It is noted that Samantha was known to Adult Mental Health services at the age of 20 years and was referred to Adult Services on one occasion. Samantha was diagnosed with paranoid schizophrenia. Samantha was in a relationship with her child's father where it was reported on two occasions that there were domestic abuse incidents. Samantha had not known that she was pregnant, and her baby was born at home. It appears that there were immediate concerns. Following assessments and further concerns the baby was placed with a member of the extended family under a special guardianship order. No other information is available to the author.

4.3. Samantha lived alone and, on many occasions, had called the police with concerns that she was being stalked, harassed, or being watched. Four months before the timeframe of the review, police were concerned and followed up on welfare checks. One of these checks was to contact Samantha's sibling. Through this contact, Police learnt that Samantha had stopped taking her antipsychotic medication when she was heavily pregnant (notwithstanding information above that it was reported that Samantha did not know she was pregnant). The sibling told Police about the removal of Samantha's baby and believed that Samantha may be suffering from postnatal depression as a result of this. Samantha's sibling also told police that Samantha had become very isolated and that before the previous Christmas, that she had not been contactable for over three months, refusing to answer the door even to close family members. Samantha's sibling stated that Samantha's father is the only family member that she now had frequent contact with. The sibling had also noted a decline in her physical appearance with weight loss and sunken eyes and appearing more distant.

5. ISSUES FACING SAMANTHA DURING THE REVIEW PERIOD

5.1. This section will briefly describe the issues facing Samantha during the period of the review as presented in the agency review reports and additional information gathered from agencies who worked with her. Section six will look in more detail and analyse the interactions and multiagency working regarding these issues.

Mental Health

5.2. It appears that the main issue for Samantha was her mental health. Information for the review would suggest that Samantha stopped taking her antipsychotic medication some four years previously and it is suggested by the author that some of the presentation of Samantha could be explained by a psychosis. Following numerous calls to the police indicating various burglary attempts, the police submitted many vulnerable adult referrals to Adult Social Care Contact Centre. The majority of these were discussed with and forwarded to NHS Mental Health services as a result of these contacts.

5.3. Over several months during the timeframe of the review Adult Mental Health Services attempted to engage with Samantha using various methods in order to assess her mental health. Only one face to face contact at home was possible and mental health services could not engage Samantha. Whilst Samantha was not found to be overtly mentally unwell, having no psychotic symptoms, she could not be engaged further as she did not consent to a full mental health assessment. It was deemed that she had mental capacity to decide that she did not wish to engage with mental health services. Information to the review stated that on this occasion Samantha was not detainable under the Mental Health Act.

5.4. On a further referral back to mental health services a year later, nothing had changed, and mental health services could not engage with Samantha. As an MDT decision noted that Samantha's presentation had reported not to have changed; a request was made to Adult Social Care to assess Samantha's mental capacity. Samantha was discharged from mental health services.

5.5. The case was allocated to a social worker one month after transfer to Adult Social Care. The social worker tried to contact Samantha but had difficulties as none of the contact numbers were viable. Eventually, Samantha's mother was contacted, and arrangements were made to visit to assess Samantha's needs.

Self-Neglect

5.6. As well as the mental health issues that professionals felt that Samantha was presenting with, she was also increasingly showing signs of self-neglect. There had been concerns raised by the Fire and Rescue Service when they had been called out by Samantha when she had been locked in her bedroom. They expressed further concerns when they had been called to enable access to the Ambulance Service as well as when they had been called to a smoke-filled room. The Fire and Rescue Service had contacted Environmental Health to support and advise about the condition of the property which was owned by a private landlord who had reportedly not been undertaking routine repairs when requested. As time went on, more of the professionals who were seeing Samantha were recording that the property was unkempt and unhealthy to live in and that Samantha did not appear to be making efforts to clean it or persist with requests to the landlord for repair. The housing benefits officer also had grave concerns on a visit they undertook five months into the review period (over a year before Samantha died). The Fire and Rescue Service advised Samantha of some safety issues that they had noticed and referred to Adult Social Care because of the circumstances that Samantha was living in.

5.7. Several professionals noted issues with finances where there were at times no gas or electricity and a broken boiler. These concerns did not appear to be addressed readily by Samantha, thus adding to her

inability to care for herself.

5.8. Those who had seen Samantha during the second year of the review period had noted that Samantha was looking dishevelled and unkempt with little evidence of any food in the house.

5.9. In the six months prior to Samantha's death, it had also been noted that there were several calls to the police by Samantha's mother and grandmother who had both been approached by Samantha for money with reports that Samantha had stolen from them and had sometimes shown aggression. Family stated that Samantha had started drinking wine and that they believed the money was being used to buy alcohol. It was also noted historically that Samantha was addicted to gambling. This was not known to any services working with her in the timeframe of the review, so it is not known whether this was still an issue.

5.10. The social work care and support needs assessment was planned with Samantha's mother for a couple of weeks after the social worker had been allocated. When the social worker arrived to undertake the assessment, there were several concerned family members present. This appeared to have a negative impact on Samantha and so the assessment was rearranged. At this point the social worker went on leave and the case was not reallocated. There was also no further engagement with Environmental Health services due to communication and reallocation issues.

5.11. The self-neglect issues were not addressed during the timeframe of the review and will be subject to further analysis in the remainder of this report.

6. ANALYSIS AND LEARNING

6.1. The analysis section takes a strengths-based approach identifying what went well and then building a picture of areas where learning has been identified, as well as further steps that should be taken to achieve stronger systems. Systems and services that worked with Samantha have been updated and improved since this case. This is due to natural ongoing improvement, service changes, and elements that have been changed already due to early learning from this review and another recently published SAR. These, as well as where agencies have identified their own learning will be noted throughout this report.

Contact and engagement

6.2. One of the main issues that services had in offering support to Samantha was that they found it difficult to contact and engage with her. Samantha would freely call the police with complaints regarding hearing noises and concerned that people were in her property and had taken things. Police believed that Samantha had mental health issues and as noted previously, prior to the review period, had contacted her sibling to find out more information which presented a picture of a person who was not taking medication for her diagnosed mental health condition.

6.3. On most occasions the police made vulnerable adult referrals (nine in total over the review period) in recognition of her need of care and support. These were sent to Adult Social Care. Discussion within the review workshop indicated that these referrals had been discussed with and sent on to either the Crisis

or assessment teams, as appropriate, within NHS Adult Mental Health services as it was Samantha's mental health symptoms that were seeming to be the pressing need.

6.4. The Fire and Rescue Service also visited three times during the time frame of the review, once when called by Samantha when she was locked in her bedroom, once at the request of the ambulance service when they could not gain access following a call from Samantha and once when two pans had been left on the hob creating a smoke-filled room (it is noted that at this point Samantha must have had gas and/or electric to enable her to be cooking; this was nine months before Samantha died and was in the spring months). On all these occasions, the fire crews used their internal escalation system to follow up on the concerns; it was noted that the situation was worse on each occasion. These escalations resulted in planned follow up visits by the Fire and Rescue Service to discuss safety in the home due to several fire risk and environmental issues of concern. The environmental concerns were reported to Environmental Health; these will be discussed within a further section within this report. There were also vulnerable adult referrals made to Adult Social Care which received responses that Adult Mental Health services were involved and that there was no open case to Adult Social Care; referrals were forwarded to and discussed with NHS Adult Mental Health Services.

6.5. The front-line emergency services were recognising the need to involve other services, making referrals to Adult Social Care that were forwarded to Adult Mental Health.

6.6. As a result of the welfare concerns raised regarding the property by fire services, the environmental health/selective licensing department had also tried to contact Samantha to no avail. Following several attempts Samantha was also visited by a housing benefits officer who found significant issues and concerns regarding mental capacity and self-neglect. These were discussed with environmental health and also referred to Adult Social Care. These contacts led ultimately to a call to Samantha from Adult Social Care Localities Team and then a visit. Whilst this visit identified some concerns it did appear that Samantha had addressed some of her circumstances as she did have gas and electricity and the boiler had been fixed. Samantha reported that she would be spending Christmas (in 10 days) at her mothers'.

6.7. During the timeframe of the review the GP had three significant contacts with Samantha. The first was when Samantha attended for an appointment on a non-relevant physical health issue. There was excellent practice by the practice nurse to undertake some routine health screening. It was noted that there was significant weight loss compared to a previously recorded weight. No action was taken to understand this weight loss, this could have been indicative of physical health complaint or indeed that Samantha was not eating enough.

6.8. On a further attendance, Samantha was accompanied by her mother three months into the review period with concerns about a non-relevant physical health concern. Samantha's mum raised concerns about her daughter's deteriorating mental health including symptoms associated with schizophrenia but with no suicidal ideation. The records show that a full mental health assessment was undertaken by the Advanced Nurse Practitioner resulting in Samantha and her mother being encouraged to contact mental health services. The GP report for this review recognises that there should have been a follow up appointment. There are now templates in use for mental health assessments to aid documentation and action. Three weeks later, a letter was received from Mental Health Services to state that Samantha had failed to attend her MH appointments (which had occurred prior to the attendance at

the GP concerning Mental Health). Two weeks after that, Samantha attended with a boil and was seen again by the Advanced Nurse Practitioner who advised Samantha to bathe. Samantha told the nurse that she could not bathe as she had no hot water as her electricity had been cut off due to non-payment. It is not recorded as to why it was necessary to advise Samantha to bathe i.e., was she looking like she had not washed or if it meant just to bathe the boil area. It is recorded that Samantha was advised to wash in the sink using warm soapy water. The GP report for this review has rightly highlighted that with more professional curiosity it might have been discerned how Samantha would be able to get warm water without electricity. The record also notes the previous non-attendance for mental health but there is no recording of Samantha's current mental health given the concerns and presentation of three weeks previously or discussion regarding the defaulted appointments. Neither of these contacts led to any follow up with other agencies or any further questioning of Samantha's circumstances.

6.9. The GP record had several discharge and non-engagement letters filed for various mental health and other health appointments and so could have led to further thought about whether Samantha would make contact with mental health services given her history of non-engagement. Although it was clear in the record that there was no engagement with mental health services, these were filed by practice staff and not flagged to the GP. From discussion with Mother and Samantha, there was a belief that Samantha lived with her mother therefore a reassurance was felt that mother would raise any serious concerns. If there had been contact with other agencies, or indeed if other agencies had contacted the GP, it might have become clear that Samantha was living alone. The GP practice has made relevant recommendations on all of these areas where learning has occurred.

6.10. Although the Adult Mental Health Services within the Mental Health NHS Trust were trying to support Samantha, none of the referrals received from any service resulted in a multi-agency response which meant that each agency continued to offer responses within their own remit which was devoid of any joined-up approach.

6.11. All services found that engagement with Samantha was difficult. When mental health services received referrals during the timeframe, Samantha was discharged when services could not engage with her. There was evidence that there were assertive attempts made to engage Samantha by all services.

6.12. There was only one face to face assessment by mental health services during the timeframe of the review following referral to the services of the safer neighbourhood mental health worker. This assessment took place at Samantha's home and was limited as Samantha refused a full mental health assessment. There was an assumption of capacity made at this visit as there was no evidence that Samantha was not fully understanding of her needs and stated that she did not want the support of mental health services. There were no outward symptoms reported that suggested that Samantha's mental health illness was so severe that use of the Mental Health Act could have been considered in order to detain Samantha for treatment without her consent.

6.13. There were several discussions related to this within the practitioner workshop for the review that provide insight into learning for the system. The first relates to whether Samantha really did have capacity or indeed whether her executive functioning really demonstrated that she could make decisions that were in her best interests and that she was able to carry out actions based on the

decisions that she had agreed to. The housing benefits officer did not believe that Samantha had mental capacity to understand the harm that her living circumstances may cause. Albeit that the Mental Capacity Act[5] (MCA) has provision for those with mental capacity to make decisions that others may see as unwise, there needs to be surety that a person does indeed have capacity where there is an impairment of the mind or brain. Where a person appears to have capacity but their continuing decisions lead to a person increasing their risk of serious harm or death, then fuller assessment and specialist advice is required that includes understanding of executive functioning. It was noted during this assessment that Samantha and her environment were in a neglected state. This will be discussed in the self-neglect section in this report.

6.14. Six months prior to Samantha's death a further referral from the police was sent to Adult Mental Health Services via Adult Social Care. There was a telephone call with Samantha's mother who also raised concerns about her daughter. It was agreed that further options needed to be considered in a multi-disciplinary team meeting within the Adult Mental Health team. The conclusion of that meeting was that Samantha would be discharged from their services, in line with policy, with a request to Adult Social Care Services to undertake a mental capacity assessment.

6.15. There are again some elements of learning here. It was not clear what decision the mental capacity assessment Mental Health Services were requesting of Adult Social Care related to. Following discussion within the review process it was discerned that this was to assess Samantha's capacity to accept or decline mental health services. Mental Health Services have considered whether there was a 'confirmation bias'[6] applied in not making further attempts to assess Samantha's capacity or to make further efforts to engage with her. The fact that her capacity had previously been assessed and that nothing had appeared to change confirmed to the team that there would be no benefit as the outcome would be the same.

6.16. The previous mental capacity assessment had been undertaken 13 months previously and the meeting assessed that Samantha had capacity then and that there were no changes in her circumstances as the concerns remained the same. The MCA assessment for the decision at that time was no longer viable and should have been repeated by adult mental health services based on the new referral and the discussion noted within the MDT meeting. The Mental Capacity Act Code of Practice[7] and NICE Guidance[8] are clear that a person should be supported with all the information possible to determine that they are fully informed of the consequences of the decision they make.

6.17. There were several decisions that Samantha needed to make using all the information available and then further assessment that she could use and weigh the information in her decision making. The Code of Practice goes on to say that professionals carrying out an assessment should be the most relevant person based on the decision being considered. The code also states that professionals undertaking

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[5] **The Mental Capacity Act 2005** came into force in 2007. It is designed to protect and restore power to those vulnerable people who may lack capacity to make certain decisions, due to the way their mind is affected by illness or disability, or the effects of drugs or alcohol. The MCA also supports those who have capacity and choose to plan for their future .https://www.scie.org.uk/mca/introduction

[6] **confirmation bias**, the tendency to process information by looking for, or interpreting, information that is consistent with one's existing beliefs. https://www.britannica.com/science/confirmation-bias

[7] HM Government. (2007) Mental Capacity Act Code of Practice https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

[8] NICE Guideline (2018) Decision-making and mental capacity Published: 3 October 2018 www.nice.org.uk/guidance/ng108

that assessment may need information from other sources in order to be fully informed of all of the issues that may affect decision making. There is no evidence that mental health services knew all of the concerns that had been raised by police and other emergency services.

6.18. During the workshop, a discussion led to the agreement that no one had asked Samantha why she would not take her medication or why she was 'choosing' to live with no gas or electricity and in an environment that was unkempt and unhygienic and why she was not caring for herself. That would lead the author to suggest that it was not clear if Samantha knew of the harm that was occurring to herself or that the number of times that she was calling the police due to alleged burglaries and other issues may have been due to psychosis or paranoia, albeit at the time of the previous MCA assessment 13 months before, there had been no symptoms displayed. It was noted that thought disorder can become chronic in those that have suffered from long term psychotic illness, but this had not been assessed in this case and is rare in the younger adult age group.

6.19. Research[9] suggests that there is a fine balance in challenging someone's apparent lifestyle choices. Respect for autonomy is seen as important but that does not prevent questioning and respectful challenge of what professionals observe.

6.20. Some of the professionals at the workshop pointed out that it may not be a lack of professional curiosity but that it can take confidence to ask the difficult questions but also agreed that it can provide more in depth understanding of a person's situation rather than not addressing the 'elephant in the room'[10].

6.21. There were then discussions between Adult Social Care and Adult Mental Health as to who would be best placed to work with Samantha. Adult Mental Health had stated that Samantha would not engage with them, so it was for the local authority team to pick up the assessment and support of Samantha. Adult Social Care felt that this was a case of mental health illness leading to self-neglect, and that Adult Mental Health Services should continue to try and engage Samantha. This was not agreed with therefore Adult Social Care placed Samantha for allocation to local authority localities social worker.

6.22. This disagreement was not escalated to a senior manager in Adult social Care to discuss and resolve. The safeguarding and self-neglect element of this will be picked up in a later section.

6.23. It does not appear that there is a local protocol for the management of transfer of cases between Adult Mental Health and Adult Social Care, to which Adult Social Care Team (localities or mental health) or a resolution of disputes policy that sits outside of safeguarding procedures. This may help resolution when there are disagreements between these services. The Mental Health NHS Trust also employs social workers, but they do not have statutory Care Act duties as they are not employed by the local authority.

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[9] Suzy Braye, S. Orr, D and Preston-Shoot, M (2013) A scoping study of workforce development for self-neglect work. University of Sussex & University of Bedford

[10] The expression **"the elephant in the room"** is a metaphorical idiom in English for an important or enormous topic, question, or controversial issue that is obvious or that everyone knows about, but no one mentions or wants to discuss because it makes at least some of them uncomfortable and is personally, socially, or politically embarrassing, controversial, inflammatory, or dangerous.

6.24. There was a conversation between an NHS Adult Mental Health Social worker and the first contact team. This was good joined up working to agree that the NHS social worker would continue at this point to try and make contact to offer support for Samantha. There is no recording of the outcome of this. Adult Social Care and NHS Trust social workers record on different systems.

6.25. A local authority social worker was allocated ten days following a further conversation between Adult Mental Health and Adult Social Care contact team that a mental health multi-disciplinary team meeting had decided that there was no more that could be offered to Samantha as they had not been able to engage her in any assessment. This was a localities social worker and not a local authority mental health team social worker. It would be better in the future if those adults with care and support needs that come from mental illness were allocated to the adult mental health team in adult social care who have the expertise of working with and assessing those whose social care needs arise from their mental illness. Adult social care has made recommendations regarding this.

6.26. The localities social worker found similar contact issues that other services had found and contacted Samantha's mother on the same day as allocation to try and gain contact with Samantha. Samantha's mother confirmed that she had seen her daughter the day before and that the concerns remained the same, the property being a mess and Samantha not showering. Samantha's mother also confirmed her mental health diagnosis, and that Samantha would not take her medication.

6.27. A visit was arranged for 10 days later for the social worker to undertake a Care Act assessment which would have included an MCA assessment if necessary. The visit was cancelled by mother when the social worker called to confirm and was then rearranged for 19 days later. When the social worker arrived, there were several family members present appearing be concerned about Samantha but making Samantha angry and agitated. The social worker rightly decided that this environment was not conducive to effective assessment but did record the conditions within the property that now included evidence of a flood. The social worker gained consent to refer to a housing association housing support worker and that the social work visit would be rearranged. The social worker contacted Environmental Health and shared concerns. Five further referrals were sent by the police over the next four weeks including one where the police had stated that they had heard rats under the floorboards. The social worker followed up with Samantha's mother regarding the proposed visit from the Environmental Health Officer confirming that this was planned for 2 days later.

6.28. It was noted in a conversation before the timeframe of the review between Samantha's sibling and Police that relationships within the family were difficult and that it was only her father that Samantha still had regular contact and good relationship with. There is no recording as to why other family members were able to be at the assessment appointment. It was felt by the review that that fact that it was Samantha's mother that was contacting agencies on occasion with concerns that this meant that Samantha would consent to her mother being with her. It is noted that Samantha did attend the GP with her mother, so it is likely that the relationship was not completely broken down. The review does find learning that there should not be an assumption and that professionals should check, in a person-centred way, who they would like to support them with assessments and appointments etc. It has been identified that there was a missed opportunity here to have asked Samantha who she wanted there and that other family members should have been asked to leave so that the assessment could have

continued on that day as planned.

6.29. The social worker then had a period of leave over the next ten weeks. Two locality mangers were also on extended leave over this time.

6.30. Environmental Health then struggled to engage with Samantha or visit the property as Samantha's mother cancelled visits due to several Covid reasons either having had Covid 19 or self-isolating. In England, concerns were beginning to rise again regarding the number of Covid infections with a new 3 tier system of restrictions being imposed during this time. It is reported that the Environmental Health Officer then left their role. It does not appear that the work was picked up or reallocated until the social worker made contact following their leave.

6.31. It was unprecedented that the social worker, two managers and an environmental health officer were all away from the case at the same time and those services have made recommendations within their single agency reports regarding these issues and gaps. The impact on Samantha though, was that there were no services actively engaging with ongoing assessment, support, and management of the issues. Ultimately it is now known that no professional had any contact with Samantha for 17 weeks before her death. The last professionals to see her were the Police who sent a vulnerable adult referral following a further report by Samantha that there were people in her house who had entered through the kitchen window. There were no signs of anyone forcing entry or in the property at that time. There was contact from Adult Social Care duty workers with Samantha's mother who was seeing Samantha.

6.32. On return of the allocated social worker there was a flurry of activity to ensure that those that had received referrals before, had followed up. The case was reallocated to an environmental health officer and the social worker discovered that the referral to the housing support worker had not happened as there had been no referral form received and that the housing support worker had also been on leave. The referral form was still not sent to the social worker for completion, who chased again two weeks before Samantha was found deceased.

6.33. The social worker rearranged a visit; when they arrived at the house; Samantha had not been seen by anyone for several days and was found deceased. There is further learning regarding the events that happened resulting in Samantha not being seen by a professional in the last four months. Although these were due to reasons stated above, there had been no multi agency working around Samantha that may have alerted professionals that Samantha had not been seen. During the workshop it was discussed that there was no framework recognised by workers regarding multi agency working outside of safeguarding. Notwithstanding the later section identifies the safeguarding framework that could have been used, there was also discussion regarding other frameworks and why these were not considered.

Points for strengthening practice

- Clarity of referral pathways, quality, recording, and feedback related to referrals provides a governance and auditable structure for learning and development of stronger practice.
- Assessing mental capacity can be complex where a person appears to be declining services and treatment for ongoing mental health conditions. Support to follow policies and guidance that is easily accessible can support mental capacity assessments.
- Protocols for transfer between services can aid clarity and understanding of transfer requests as well as provide escalation and dispute resolution routes.
- Covid 19 restriction had an impact on ability to gain access to people where there are concerns.
- Professional curiosity can be aided by support to gain confidence to ask difficult questions.
- Person centred assessments ensure that the person can be supported by those that they choose.

Multi Agency Frameworks and Processes

6.34. In the section above it has been detailed that each agency not only struggled to engage with Samantha, but where contacts did occur, there was no multi agency response. Professionals had not been able to understand why Samantha did not want to engage with support to help her circumstances. Multi agency work and planning could have included understanding best ways to work with Samantha as well as the best organisation to lead with Samantha, that might not have been mental health as she did not appear to want to recognise that mental illness may be the driver for her living circumstances.

6.35. Referrals were all sent to Adult social Care but there was no multi agency discussion regarding these before decisions were made as to best routes/pathways for that referral. Gathering of important information known to key agencies can support decision making. Multi Agency Safeguarding Hubs (MASH)[11] are a method if undertaking this activity, with the co-location and/or co working of information gathering. The Safeguarding Adult Board have recognised that the development of and Adult MASH is a key priority within their three-year strategic plan. This will support multi agency working and decision making at the point of referral or soon after.

6.36. It has also been identified that there were processes that could have been used that would have brought agencies together outside of the safeguarding process.

6.37. At the time there was a Community Multi Agency Risk Assessment Conference (C-MARAC) that was available having been established by the police. Whilst this was a useful multi agency forum tool, it was not used for Samantha. Police have identified that it is likely that response officers responding to crime reports would be less knowledgeable about C-MARAC than community officers. Other agencies were also able to refer to C-MARAC but non referred Samantha. The author would suggest that this was because it was not identified that C-MARAC would add any benefit in a case of this nature.

[11] Multi-agency safeguarding hubs are structures designed to facilitate information-sharing and decision-making on a multi-agency basis often, though not always, through co-locating staff from the local authority, health agencies and the police. https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/collaborative-working-and-partnership/multi-agency-safeguarding-hubs.asp

6.38. Following learning from audits, SARs (mentioned previously) and DHRs locally, it was identified that C-MARAC had some limitations in managing ongoing multi agency risk. C-MARAC has a representative from each agency, but this is not the frontline worker that knows the person. It does not require consent or knowledge of the person that it is taking place, although many professionals would seek consent and inform the person that they had been referred. There is no ongoing review process where cases are brought back for an update. It takes a positive risk and problem-solving approach that is beneficial in some cases.

6.39. From the reviews detailed previously it was identified that where cases have ongoing complexities, a more in-depth multi agency approach is required. There needs to be involvement of those working directly with the person that results in an action plan that is reviewed at follow up meetings. The Vulnerable Adult Risk Management (VARM) meeting was a process that had been previously in place that C-MARAC had replaced. It was therefore identified that there needed to be both processes as C-MARAC could refer on to VARM where a one-off meeting identified that there was a need for more than a swift problem-solving meeting. It was proposed that both are chaired by the Police. By using a VARM process, the Care Act principles of person-centred assessment and Making Safeguarding Personal could be incorporated and involve the person in the concerns that surrounded them. The Making Safeguarding Personal (MSP) initiative began as far back as 2009 by the Local Government Association and Association of Directors of Adult Social Services[12] to ensure outcome focussed, person centred responses to adult safeguarding, rather than it being a process that happened to people without knowledge. This has since become enshrined in the Care Act (2014) and requires that the adult and /or their representative is part of the safeguarding process. The author would suggest that as the proposed process is more akin to social work and health casework that the chairing of this should be reconsidered.

6.40. It was also recognised that there are occasions where more senior management and/or leaders need to be appraised of cases; VARM has a linked senior management meeting, the Vulnerable Adults Panel (VAP). Proposals were put to the Board and Community Safety Partnership just under a year before this SAR. There has been very little progress with this work and this review will seek to expedite this work in light of the additional learning from this review.

6.41. If these processes are to be robust then, based on the experience of the author from work by other SABs there will need to be clarity regarding the following:

- Threshold criteria for referral.
- The right designation/organisation for the Chair or to rotate Charing
- Escalation process.
- How safeguarding processes under the Care Act sit within the process map.
- Can VARM run alongside a Section 42 Enquiry[13] or is it separate?
- Does VARM stop when Section 42 starts and/or vice versa?
- Is there a step up and step-down process?

[12] Lawson, J. Sue Lewis, S & Williams, C. (2014) **Making Safeguarding Personal** 2013/14 Summary of findings London, LGA

[13] **The Care Act 2014 (Section 42)** requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. 2014 HM Government The Care Act 2014; https://www.legislation.gov.uk/ukpga/2014/23/resources

    - Are agencies committed to attending VAP at the right level rather than delegation?
- How is assurance gathered on the efficacy of the system?

Points for strengthening practice

- Multi agency working can benefit an individual especially where resistance to one service is recognised.
- Multi agency working provides the best way of understanding how best to engage with a person
- Frameworks for multi-agency engagement can ensure risk is recognised and manged at the right level.
- Entry and Exit points for services need clarity to ensure that interface with other policy frameworks provide ongoing support for those at risk of harm.

Housing

6.42. The tenancy that Samantha had was a joint tenancy with her mother rented from a private landlord albeit that professionals indicated that Samantha spent most of her time living there alone. This house was in a selected licensing area[14]. The purpose of selective licensing is severalfold, however one of the stated reasons is to improve the quality of the property conditions within the selective licencing area. There is a requirement for the landlord to be licenced and to comply with safety and maintenance regulations. The house had been inspected 3 years before the timeframe of the review with several breaches noted; these were reported to have been fixed following a further inspection. On first referral to Environmental Health at the start of the review period, an officer gained access to speak to Samantha. There was no electricity due to having no credit on the prepayment meter. This also meant that there was no heating. There was no other description of the property by the officer at this time.

6.43. When fire officers returned for another incident the following month there were further concerns raised including a leaking boiler and no gas check in place. It is noted that environmental health officers then went out to visit again for breaches against the landlord. These were due to drainage and garden concerns. It does not appear that the concerns raised by the fire service were dealt with at this point. No access was gained to the property; it was felt that was not required due to the nature of the reported breaches. Continued attempts to engage with Samantha were not successful. Had access been gained to the property, other breaches would have been noticed and was a missed opportunity to take further action against the landlord and enforce repairs.

6.44. It was another two months before the social worker contacted Environmental Health over the conditions that were found following their visit. This was four months before Samantha passed away. A further environmental health visit never took place. It is known that the conditions deteriorated further. There were several reasons that the visit did not go ahead. Samantha's mother cancelled on three occasions because of the covid issues mentioned in a previous section. The officer involved then left the role. There was no follow up because of allocation system errors in environmental health teams

[14] https://www.rotherham.gov.uk/private-housing/landlord-licensing-1st-may-2020/3

and compounded by lack of chasing by the social worker due to their leave.

6.45. There was again no multiagency working related to the housing conditions. The lack of heating within the earlier months would not have been such an issue due to it being summer, but as winter approached and arrived, Samantha still had no working boiler and struggled to keep credit on her prepayment meter. None of this was seen in the context of a vulnerable person living in deteriorating housing conditions. Police were also now identifying that Samantha had started to become aggressive with family and stealing from them as she tried to get money. This apparent lack of money would have also had an impact on her ability to buy food; the knowledge that Samantha had started drinking wine was not put together within the context of a person who had little money for electricity.

6.46. When the benefits officer visited, it was found that Samantha was only wearing a vest top and stated that the radiators were hot and that she was therefore not cold. The benefits officer stated that the property was very cold and that the radiators were freezing cold. The benefits officer also discussed Samantha's weight loss. She was very resistant to any kind of help or intervention and discussed making enquiries about a support worker etc as she wasn't responding to letters etc. Samantha continued to tell the officer she was ok and could manage her own affairs. The benefits officer discussed food and whether she had the money to eat. Samantha stated she had tried to lose weight and that her weight loss was down to all the walking she was doing and was proud of her weight loss. The benefits officer told the review that whatever was raised, Samantha just shrugged it off and didn't see it as a problem. The benefits officer stated that it was also apparent that Samantha had been drinking, so didn't expect a completely rational response.

6.47. Whilst this indicated possible mental health issues, it is further evidence that alcohol was a possible issue. The visit also evidences that the landlord had not addressed the issues of the gas boiler being broken and this was now winter. The author has found that the temperature on the day of the benefits officer's visit in winter ranged from two to five degrees Celsius. (It is noted that at a visit later in that week the boiler was fixed and there were gas and electricity).

6.48. It is important to note that had the environmental health officers been aware of all of the concerns, that had been identified, they do have a power of entry under certain circumstances. Again, it would have needed a full multi agency approach so that Samantha's circumstances could have been fully explored and decisions made as to whether the threshold was met for environmental health officers to invoke this power of entry.

6.49. Environmental Health have recognised the learning for their organisation and made recommendations within their single agency report to manage absences and investigate housing circumstances more robustly.

Points for strengthening practice

- Gathering information from a wide range of sources to ensure all those in provision of enforcement powers for use with the private rented sector can exercise those powers to ensure intended outcomes for vulnerable people.

Self-Neglect; a safeguarding issue

6.50. There were many aspects in the last 18 months of Samantha's life that indicated self-neglect. Self-neglect is defined in the Care and Support Statutory Guidance[15] as:

> 'a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'.

- Lack of self-care (e.g., neglecting personal care, hygiene and health; poor diet and nutrition) and/or,
- Lack of care of their domestic environment (e.g., neglecting home environment, hoarding and excessive clutter) and/or,
- Refusal of services that could mitigate the risk to safety and well-being (e.g., lack of engagement with health and/or social care staff and other services/agencies)

6.51. This identifies that Samantha fitted the criteria of self-neglect; she was at risk of harm because of her lack of self-care for her physical and mental health needs. The guidance mentioned above also states that:

> 'It should be noted that self-neglect may not prompt a Section 42 Enquiry[16]. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support'

6.52. Samantha was suffering from a mental illness that required medication but that she refused to take it. Samantha was also suffering from trauma of having her child removed and possible other trauma from her childhood having been subject to support from children's social care herself as a child. All of these can be issues that can lead to a person self-neglecting and not engaging with support services. The author would suggest that Samantha did not have agency and control of her own behaviour because of outside influences. Research suggests that lack of agency is of particular concern in those with schizophrenia[17] and may have been an underlying reason for Samantha's self-neglect and why self-neglect can often be seen in those with schizophrenia. Other research indicates that symptoms of schizophrenia can include impaired drive and motivation to the extent of self-neglect[18]. Schizophrenia therefore should be considered as a pre-empting factor in self neglect; this was not recognised.

6.53. There were several issues that impacted on professionals' recognition of self-neglect and a multi-agency response to this. Firstly, as discussed previously, most referrals into Adult Social Care from the emergency services, albeit that some mentioned self-neglect specifically, were directed to Adult Mental Health with the belief that the issues were being driven by Samantha's mental health illness. Whilst this

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[15] **Care Act Guidance: Care and Support Statutory Guidance** (2020) https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance Updated 2022 with no changes to Chapter 14 Safeguarding

[16] **The Care Act 2014 (Section 42)** requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

[17] Moore, J. W. (2016) **What Is the Sense of Agency and Why Does it Matter?** Front. Psychol., 29 August 2016 https://doi.org/10.3389/fpsyg.2016.01272

[18] Williams H.J. (2009) Schizophrenia genetics: new insights from new approaches, British Medical Bulletin 2009; 91: 61–74

was the case, Samantha's non engagement with mental health services and assessments that identified she had mental capacity to decide not to engage, meant that Samantha was discharged from mental health services.

6.54. The elements of self-neglect of her environment, herself and indeed neglect of her own mental health treatment were all elements of self-neglect that required a different response, however mental health was seen as the only issue on receipt of these referrals, and this was not linked to self-neglect. When assessment and review coordinators[19] from Adult Social Care did visit, they found that some things had been resolved and that they were not as concerned as referrals had suggested they might be. The later social worker visit did not highlight urgent concerns and the visit did not continue due to other family members being present.

6.55. Secondly, the police continued to be called and identified the need to refer on, but were not able to identify that the circumstances, despite previous multiple calls and referrals should be escalated as a vulnerable repeat caller or referred to C-MARAC as could have been done at that time. There was no system identification that despite numerous referrals, that the overall situation for Samantha did not improve. This was because the police were focussing on the crime element in that they were being called out to reports of burglary. When they were then finding that it was mental health, they were duly referring to adult social care which, in fairness, was the appropriate pathway. The College of Policing have identified the need for more training on vulnerability and seeing beyond the obvious. The referral form that the police use is also being updated in conjunction with Adult Social Care so that the information is more robust. It is hoped that this and other multi agency frameworks will lead to improvement in how vulnerable repeat callers are managed and that the cumulative risk is seen and escalated.

6.56. Further, on final discharge from mental health services, there was a delay in the assessment by Adult Social Care and then periods of leave in several services as well as the impact of Covid limiting visits, meaning that the deterioration in Samantha's presentation, increasing consumption of wine and the issues that police were being called about where Samantha was an alleged perpetrator against her mother and grandmother, were not put together in context.

6.57. Each service had several concerns at different times, some issues did improve slightly for a while, but it does not appear that these were sustained. With no multi agency safeguarding response, the whole picture was not put together.

6.58. Within the timeframe of the review where Samantha was being seen by professionals, albeit she was not engaging, there was no multi agency policy and procedure for self-neglect in place. This was being written at the time based on learning from the two other SARs mentioned previously. The new policy was launched ten weeks prior to the death of Samantha. There is a current refresh underway which will include the learning from this SAR as well as a clear integration of the processes for multi-agency

[19] **Assessment and review coordinators** are vocationally qualified staff who support the Council's statutory duties in relation to Adult Social Care, ensuring that the principles of 'Prevent, Reduce & Delay' are applied at all times including a focus on strength based approaches to assessment and support. They provide information, advice and guidance and manage a caseload of activity in accordance with the role. They undertake assessments autonomously such as Care Act assessments, carer's assessments, mental capacity assessments, contribute to safeguarding and best interest decisions.

working such as C-MARAC, VARM and VAP which again have been identified as a need following the previous SAR mentioned. This evidences that the SAB is reacting to learning and it will require thorough audit of all processes mentioned to ensure that the learning and updated systems are having an impact on those who self-neglect.

6.59. In reviewing the current policy and procedure for self-neglect it will be important for there to be a careful review of research evidence related what has been found to work best when working with adults who self-neglect.

6.60. It is recognised in research[20] and Safeguarding Adult Reviews[21] that working with cases of self-neglect can be particularly complex. The research (ibid) recognises that there is a need for practitioners to understand self-neglect and to develop skills in effective interventions. There are some key elements to best practice approaches to working with people who self-neglect:

- Importance of relationships
- Understanding the person
- Legal literacy
- Creative interventions
- Effective multi-agency working

6.61. It is noted that most of these elements were missing from work with Samantha, again because of the issues that this review has identified above. The lack of self-neglect guidance was also highlighted as learning from the SAR David and the Painter and his son [22].

6.62. Self-neglect was mentioned in several vulnerable adult referrals but did not result in a safeguarding response. Whilst these were sent to Adult Mental Health, Adult Social Care should have recognised the need for consideration under section 42 as per the Care Act. Whilst the decision may have been that the threshold for Section 42 was not met, there could have been other responses. Firstly, in recognising safeguarding issues, Adult Social Care should have sought information from other organisations e.g. The GP and Adult Mental Health. This would have helped inform decision making. If it was felt that the threshold for Section 42 was met, it may have been appropriate to cause Adult Mental Health to undertake enquiries and feed back to Adult Social Care. It is the local authority that always maintain the lead coordination role in safeguarding enquiries.

6.63. There is currently no requirement within procedures or practice for referrals to Adult Social Care to be followed up in writing. There is an online referral form, but the information requested is limited and may not be a robust aid to information sharing and decision making. Information taken over the phone may be subject to mis interpretation particularly where professions have a tendency towards organisational jargon. E.g., medical person referring to a call handler. Any rationale for not seeking consent can also be included in a referral form online which would help support risk management and data protection and confidentiality. If all calls were followed up in writing it would be easier to attach

[20] Braye, S. Orr, D. & Preston-Shoot, M. (2015) Self-neglect policy and practice: key research messages. Social Care Institute for Excellence available at https://www.scie.org.uk/publications/reports/report46.pdf

[21] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews', *Journal of Adult Protection*, 17, 1, 3-18

[22] Manson/RSAB (n2)

these to the electronic care record for the person. As stated, before this would allow for cumulative risk to be identified. By having this audit trail, it is also easier for those that have referred to escalate where they are concerned that a referral may not have received the response they were expecting. It is also possible to identify where referral information is not robust as being a cause for inaccurate decision making when information is in writing.

6.64. There is no requirement for referrals to be acknowledged, although electronic forms submitted do send an automatic receipt response. Feedback is not routinely given on the outcome of the referral. Both systems would enable audit trails and professional challenge. The referral pathway into Adult Social Care therefore needs to be clarified and should enable audit of all referrals into the service whether for Safeguarding or Care Act assessment.

Points for strengthening practice

- Professionals require clear guidance for areas of work that are complex such as Self Neglect
- Professionals benefit when new guidance is supported by a programme of ongoing training and supervision.
- Understanding frameworks both within and outside of Section 42 helps professionals ensure that those who self-neglect do not fall outside of support networks and risk can be managed appropriately.
- Safeguarding referral pathways require clarity to all agencies to inform robust decision making and risk management.

7. SUMMARY AND CONCLUSION

7.1. In summarising the learning from this review, it is useful to use a model for a whole system approach used in other adult safeguarding research literature[16] (see figure 1). This model shows how each domain interlinks with the next around Samantha, making her the focal point as in the Making Safeguarding Personal requirement.

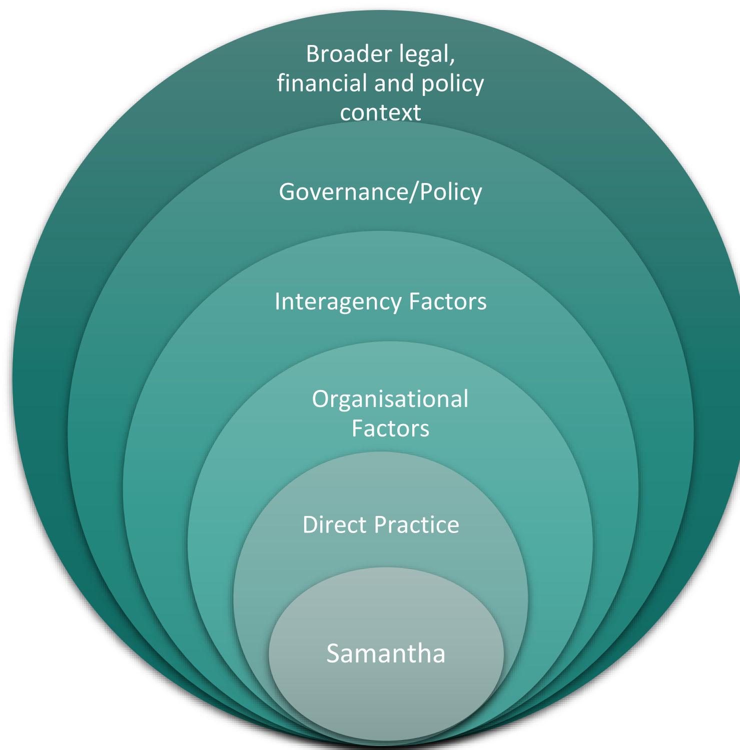

Figure 1. Whole system model from Preston Shoot, M. Shoot (2020) **Adult safeguarding and homelessness A briefing on positive practice** Local Government Association. Pp 8

7.2. The SARs previously mentioned found much the same learning. This SAR, however, will frame learning using the above model and will point out the similarities and differences.

7.3. Samantha at the centre of the review had some clearly different characteristics, she was a much younger person and female. Samantha had a mental health diagnosis and was only known to one or two services at a time.

7.4. The direct practice by professionals who saw her in crisis was good, with recognition of some of her needs and the understanding that she needed input from other services, namely mental health, social care, and environmental health.

7.5. Professionals found it difficult to engage with Samantha and this was where organisational factors had an impact. Within mental health services, there was an inability to continue to try and engage with Samantha as she was stating that she did not want help. Samantha's mental capacity was discussed within a multi-disciplinary team meeting, and the organisation referred elsewhere to undertake further mental capacity assessments. This showed a gap in understanding of mental capacity assessment requirements within the organisation. The absences of personnel in social care and environmental health were not addressed organisationally, resulting in Samantha not being seen for several weeks. Issues with mental capacity were also found within the other SARs but there was only involvement with mental health services in one of the other SARs.

7.6. From an interagency perspective there was no recognition by any agency that there needed to be a wider multi agency response indicative of an appropriate response to self-neglect.

7.7. It has been recognised in the previous SARs that there was no policy in place to guide practitioners of how to manage self-neglect nor an understanding by frontline practitioners in any organisation that this was what was required. There were mentions of self-neglect in some referrals but no recognition by those who could coordinate a safeguarding response (the local authority or mental health services) that the presentation of Samantha was because of self-neglect. As stated much of this has been addressed by the previous SARs but was not in time for a different response to Samantha.

7.8. The final layer around Samantha was the wider policy context. There has been much research into self-neglect and what works nationally over several years; this had not filtered down to the board and its member organisations but is now being addressed.

7.9. Nationally there is a building amount of case law regarding people with capacity who self-neglect, however self-neglect was not identified, therefore the requirement and threshold to seek further legal advice was not recognised. The Mental Capacity Act and Code of Practice were not well understood despite these having been around for many years.

7.10. The restrictions related to Covid 19 also had an impact on the assessment as several appointments were cancelled by the family due to the covid restrictions in place at the time. This was unfortunate but unavoidable and is being addressed with several areas looking at the UK covid response on safeguarding.

7.11. Whilst at first look, it could be suggested that there has been no improvement from learning from the previous SARs, it must be remembered that these were not completed long before Samantha died. It is important to note, however that within the agency reports and information for this SAR, the learning from the previous SARs is not mentioned; this is either learning for IMR authors or RSAB on how learning is built on from SAR to SAR as per the SAR Quality Markers[23] and Analysis of Safeguarding Adult Reviews[24]. The structure and function of the Board related to how learning from SARs is embedded has recently been reviewed in order to ensure that each organisation who is represented on the Board and within its subgroups takes responsibility for their role in shaping recommendations and action plans and that those actions lead to sustained change that can be evidenced by audit. This has been included in the three-year strategic plan for the Board.

7.12. The findings of this review also mirror some of those found by researching self-neglect SARS[25], in particular related to the understanding of assessment of mental capacity where there may be concerns related to executive functioning.

[23] Sheila Fish, S. (2018) Safeguarding Adult Review Quality Markers checklist; Supporting dialogue about the principles of good practice Social Care Institute for Excellence © SCIE & RiPfA 2018

[24] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020), National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement, LGA/ADASS, London. https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

[25] Preston-Shoot, M. (2021) On (not) learning from self-neglect safeguarding adult reviews The Journal Of Adult Protection j VOL. 23 NO. 4 2021, pp. 206-224, © Emerald Publishing

7.13. Moving forward it will be important to build all of this into future SARs and SAR processes supported by the refreshed SAR Quality Markers and the RSAB's three-year strategic plan.

8. RECOMMENDATIONS

The recommendations are built around the noted areas that require consideration of stronger practice. These recommendations recognise the strategic plan to develop an Adult MASH and therefore does not make the same recommendation within this SAR.

1. Learning from Previous SARS

1.1. RSAB should seek to collate all recent learning from SARs related to self-neglect and create one self-neglect action plan. The current response to self-neglect should be tested as a baseline using multi agency case file audits following publication of this SAR and at some point in the future to assess how well learning has been embedded. This is in line with the strategic plan for RSAB.

2. Referral and decision making

2.1. In the development of the new referral system as per the RSAB strategic plan the following must for part of the process:

- Gathering of more robust and relevant written information related to exact nature of the referral, issues of consent including reason for no consent, mental capacity and evidence of MSP where appropriate.
- Feedback to the referrer on outcome of referral.
- How to escalate and challenge if referrer continues to be concerned and no action is taken on referral

2.2. RSAB to seek the development of a Transfer Protocol between Mental Health Trust and Adult Social Care that includes clarity on lead roles, challenge and escalation and dispute resolution.

3. Multi Agency Frameworks and Processes

3.1. RSAB must escalate and expedite VARM guidance that includes:

- Threshold criteria for referral.
- The right designation/organisation for the Chair or to rotate Chairing
- Escalation process.
- How safeguarding processes under the Care Act sit within the VARM process map. e.g. Does VARM stop when Section 42 starts and/or vice versa?
- Where CMARAC fits in
- Is there a step up and step-down process from other processes?
- Commitment of agencies to attend VAP at the right level rather than downward delegation.
- Assurance gathering on the efficacy of the system.

4. Self-Neglect; a safeguarding issue

4.1. RSAB to update the Self-neglect policy and procedures incorporating all new learning from this review.

- Ensuring a multi-agency response with guidance on which agencies may need to be considered to include.
- Flow charts of each stage of process including signposting and other processes, downloadable for ease of reference
- Responses outside of S42
- Engagement with difficult to engage people
- Policy and process in one document so all in one place rather than separate
- Identify where VARM and other processes fit with self-neglect
- Importance of being professionally curious.

4.2. RSAB Subgroups to spotlight Self Neglect and being professionally curious during Safeguarding Adult Awareness week (November 2022).

4.3. RSAB to ask that the appropriate RBC Department provides a presentation and briefing regarding how Selective Licensing may work together with other organisations to protect against harm from self-neglect.

5. General Learning Briefing

5.1. RSAB should consider various methods of sharing the learning from this review e.g. podcast, video, etc. as well as the traditional learning briefing.

5.2. A case study should be developed to support individual and team reflection and for use in single and multi-agency training.

Appendix One

Terms of Reference and Project Plan (Redacted)

1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and NTSAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.
- Be proportionate according to the scale and level of complexity of the issues being examined.
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.

- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within.
- Develop an understanding who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened.
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case.
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels.
- Make use of relevant research and case evidence to inform the findings of the review.
- Identify what actions are required to develop practice.
- Include the publication of a SAR Report (or executive summary).
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary known from referral and scoping

Samantha was a 33yr old female, who had longstanding mental health illness and diagnosed with paranoid schizophrenia who was found deceased in2021, further to Covid symptoms (as reported to the fire service by her mother).

Samantha lived alone in a private rented property – poorly maintained by the Landlord, in need of repairs and in a neglected state. Samantha had been noted by services to be dishevelled and struggling to care for herself in the previous months.

Samantha was known to a range of services who she found difficulty engaging with. Samantha's mother reported to services that Samantha had not been taking her medication and since that time had deteriorated significantly.

Police received multiple calls from Samantha with concerns that there were intruders in her property and that she could hear people in the house. None of these incidences were found to be as a result of any evidence of intruders.

Samantha's mother contacted services with concerns that she had not been able to get in touch with Samantha for several days. The social worker attended the property and gained information from neighbours and the corner shop that no one had seen Samantha for 3 or 4 days. Police and fire service were called to gain entry to the property where they found Samantha deceased. It was

thought that she had died a few days previously.

The coroner recorded death by natural causes from an Idiopathic thrombotic pulmonary embolism.

3. Decision to hold a Safeguarding Adults Review

The Safeguarding Adults Review Committee of the Safeguarding Adults Board met to consider the case for review. Following the collation of chronologies, the case was further considered. It was agreed by all members present that a statutory Safeguarding Adults Review was mandated and made a recommendation to the RSAB Independent Chair. The Independent Chair endorsed this decision.

4. Scope

The review will cover the period from June 2019 until the date of death. Information will also be sought from agencies regarding background information and key events prior to the scoping period. The date is chosen to represent key points in Samantha's contact with agencies and to allow reflection previous practice to ensure strengthening of systems where necessary.

5. Methodology

The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

RSAB chose to use a methodology that engages frontline practitioners and their line managers. Agencies are asked to review their own involvement and provide a report of their findings and learning. Those who were involved, alongside the authors of the reviews will then be invited to engage in a workshop undertaken using virtual meeting technology or fact to face if Covid restrictions allow. The workshop will focus on gathering more information and be set the task of exploring the themes and learning. The themes will be identified from the chronologies and reports that have been undertaken by agencies. This will lead to identification of areas for learning and improvement.

6. Key Lines of Enquiry to be addressed

The following case specific key lines of enquiry will be addressed.

6.1. Contact, Assessment, Care and Review

6.1.1. What contact and subsequent assessment did your agency undertake of Samantha's holistic needs, inclusive of physical and mental health?
6.1.2. How robust was this?
6.1.3. How did this inform care planning and interventions?
6.1.4. What services were offered, and/or referrals made as a result?
6.1.5. What difference did contact with Samantha make to her life?

6.2. Engagement

6.2.1. How well did your service engage with Samantha?

6.2.2. Please analyse any strategies used that encouraged Samantha to engage.
6.2.3. What actions were taken if your service were not able to engage with Samantha?

6.3. Mental Capacity Act

6.3.1. Was the Mental Capacity Act applied robustly at points where it should have been?
6.3.2. Please evidence how the Mental Capacity Act was applied at various decision points.
6.3.3. What part did Mental Capacity play in understanding the how Samantha managed her life?

6.4. Housing Circumstances

6.4.1. What actions were available to services to improve the conditions of the property?
6.4.2. How did your agency support and address the ongoing need to resolve the circumstances that Samantha was living in?

6.5. Self-Neglect

6.5.1. When was it recognised that Samantha was self-neglecting?
6.5.2. What was your agency's response to Samantha's apparent self-neglect?
6.5.3. What part did safeguarding referrals, processes and procedures play in protecting Samantha from serious harm through self-neglect?

6.6. Family Involvement

6.6.1. How did your agency engage with Samantha's family?
6.6.2. What did you understand of the relationship between Samantha and family?
6.6.3. How was contact with her child managed?
6.6.4. How were family included in plans and assessments?
6.6.5. How were family carers recognised and how were their needs assessed?

6.7. Communication

6.7.1. What examples of strong communication & information sharing were evident during the scoping period?
6.7.2. Where did communication and information sharing fall short of what was expected and why do you think this was?

6.8. Support and Supervision

6.8.1. What evidence is there of positive support and supervision for professionals involved in this case?
6.8.2. How did this support professionals to engage and what impact did it have on support for Samantha?

6.9. Covid 19 Pandemic impact

6.9.1. What evidence is there of any positive or negative impact of the Covid 19 restrictions on either professionals and/or Samantha and her family

6.10. Equality and diversity

6.10.1. Was practice sensitive to any protected characteristics in line with the Equality Act (2010)

7. Independent Reviewer

The named independent reviewer commissioned for this SAR is **Karen Rees.**

8. Organisations to be involved with the review:

The following organisations will be asked for Agency Review Reports:

- Mental Health NHS Foundation Trust
- Local Council
    - Social work Locality service
    - Mental health social work
    - Safeguarding
    - Housing
    - Environmental Health
- Acute Hospitals and Community NHS Foundation Trust
- Fire and Rescue Service
- Police
- Ambulance Service NHS Foundation Trust
- Drug and Alcohol Services
- GP practice supported by Clinical Commissioning Group

The following organisations/services will be asked for background information to support the review:

Children's Social Care

9. Family Involvement

A key part of undertaking a SAR is to gather the views of the family, involve them in the review and share findings with them prior to publication. RSAB has made contact with Adult Samantha's mother, inviting her to be involved. Other family members will also be contacted.

Project Plan dates:

1.	Scoping Meeting	29/11/2021
2.	Terms of Reference agreed	29/11/2021
3.	Agency Authors' briefing	20/12/2021
4.	Agency Review Reports submitted	04/02/2022
5.	Review of reports by Independent Author	7-9/02/2022
6.	Distribution of reports & workshop details to all workshop attendees	14/02/2022

7.	Workshop Briefing (1hour)	23/02/2022
8.	Learning and Reflection Workshop	01/03/2022
9.	First Draft Overview report to all attendees	28/03/2022
10.	Recall Workshop	05/04/2022
11.	V2 Overview report circulated to attendees for info and panel	25/04/2022
12.	Panel meeting	04/05/2022
13.	V3 and Recs to Panel	12/05/2022
14.	Panel meeting to finalise report and build Recs	19/05/2022
15.	V4 and final Recs to Board	TBC (learning briefing to practitioners if delay to Board presentation)