Cumbria Safeguarding Adults Board

Safeguarding Adults Review

'Sarah'

Overview Report

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Contents

1. Introduction

1.1. This Safeguarding Adult Review (SAR) concerns 'Sarah.' Sarah was a white woman of British heritage who was in her forties when she died from self-neglect. Sarah had lived with her father in their Housing Association property. Sarah's father had described her as having undiagnosed mental illness.

1.2. Sadly, Sarah's father died. Her aunt and uncle were very concerned that Sarah would be unable to care for herself. They approached different agencies to try and get support for her. Police, Housing, Health services and Adult Social Care were all aware of concerns about Sarah. Agencies endeavoured to contact her to offer support, but Sarah did not respond or declined services.

1.3. Three months after the death of her father, Sarah's body was found at her home. She had died some weeks earlier. The pathologist was unable to determine the cause of death. The coroner recorded the conclusion as self-neglect and issued a report under Regulation 28[1] to Adult Social Care.

1.4. This SAR explores responses by agencies to Sarah and her father to identify learning for individual and multi-agency safeguarding practice.

2. Summary of the Learning Points from the Review

Learning Point 1: Prevention

Informal carers can play a crucial role in supporting adults with care and support needs. Carers may not recognise their role as carers and miss out on crucial financial, practical and emotional support. Carers may well have vulnerabilities and complex needs of their own. Agencies need to be proactive in reaching out to carers to support them, and to make advance plans for them and the cared for person, for a future point where they may be unable to continue providing care.

There were missed opportunities to recognise and respond to escalating carer stress and to consider risk of domestic abuse.

Learning Point 2: Empowerment

Making Safeguarding Personal (MSP) should be the bedrock for Safeguarding Adult practice. However, MSP must not be interpreted simplistically. Practitioners must be assured that adults have sufficient information to make informed decisions. Practitioners must also be vigilant to signals that may call into question an adult's mental capacity to make the relevant decision and take the necessary steps to assess this. MSP encompasses duty of care and even where an adult has capacity, reasonable steps must be taken to respond to identified need, proportionate to presenting risks.

Engaging adults who may be resistant to support, needs to be approached through sensitive tenacity, and creativity in reaching out.

Agencies must be attuned to hearing concerns from families and carers, demonstrating flexibility in how referrals are made and ensuring families and carers are kept involved and informed of responses to those concerns.

[1] Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths.

Learning Point 3: Protection and Proportionality

There were some good examples of practitioners being vigilant to concerns about Sarah and being proactive in following this up. However, there was also repeated examples where there was a lack of this professional curiosity and an episodic approach to incidents.

This SAR reiterates learning from other SARs, about the need for practitioners to be professionally curious: to question and delve deeper to gain understanding of a person's situation, including their needs and risks.

Where concerns of 'self-neglect' are raised, this needs to be formally evaluated, including the likely trajectory. Responses must be informed by CSAB self-neglect guidance and relevant legal framework.

Professional leadership and supervision is essential to support evidence based practice and defensible decision making. A recurrent message from SARs is that lack of engagement does not equate to lack of risk.

Learning Point 4: Partnerships

Multi-agency working at the earliest stage is essential in addressing concerns of self-neglect. It brings together information, gives greater breadth to professional expertise and leads to a shared assessment of need and risks. Importantly, it should facilitate a well-coordinated plan, with an identified lead to ensure ongoing communication and review.

Multi-agency forums can be highly effective in responding to self-neglect, where a Safeguarding Adult Enquiry is not yet required. However, the forums need to demonstrate safeguarding minded practice and attendees need to be adequately equipped to make effective responses to concerns of self-neglect. The absence of effective multi-agency working meant that no agency took responsibility, and no-one followed up Sarah.

Learning Point 5: Accountability

The lessons highlighted within this review, reflect learning themes from other reviews.

Systems need to support practitioners in working with self-neglect and resistance to engagement. Practitioners need time to be able to evaluate, to be professionally curious and take the additional measures needed.

The restructuring of the County Council offers an opportunity to revisit the point of access to Adult Social Care to ensure it provides an open door, an appropriately skilled workforce and is supported by resilient systems.

3. Context of Safeguarding Adults Reviews

3.1. The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together.

3.2.The purpose of SARs is '[to] promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again'.[2]

[2] HM Government Care and support statutory guidance Updated 21 April 2021 https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1 {Accessed May 2021]

3.3.The SAR criteria were judged to be met because Sarah was believed to have care and support needs and died due to self-neglect. The Cumbria Safeguarding Adults Board (CSAB) identified potential learning in how agencies had worked together to assess Sarah's needs and to provide support to her.

3.4. CSAB commissioned an independent author, to carry out this review. Sylvia Manson is an experienced chair and author of reviews and is independent of CSAB and its partner agencies.

4. Terms of Reference and Methodology

4.1. Terms of Reference

4.1.1. The specifics areas of enquiry are as follows:

Terms of Reference: Areas of Enquiry
1. Safeguarding Concerns I. To what extent were agency responses timely, appropriate, and effective in providing early intervention to meet Sarah's needs II. Did the referrals from professionals and family prompt any escalation or further action either within individual or to partner agencies? III. Was the rationale appropriate for the decision making in response to referrals and request for assessment of Sarah's needs? IV. Did practitioners consider the issue relating to consent from Sarah for referrals and explore their duty of care to override consent. V. Were there any triggers which should have prompted further action or exploration? What were the missed opportunities? VI. Were any strategies used to engage with Sarah? When Sarah didn't engage how did practitioners respond and was there any escalation. VII. How well did practitioners make objective and reasoned decisions, free from bias and assumptions?
2. Risk Assessment I. Was there any consideration of Sarah's mental health and capacity to understand the risks self-neglect presented to her physical health? II. Was any risk assessment undertaken as a result of the cumulative nature of the concerns raised? III. Were the potential risks identified and could this have been improved? IV. Was the risk of Sarah's situation deteriorating further considered? (statutory prevention duties, Chapter 2 Care Act). V. Did practitioners consider the risks presented to Sarah following the death of her father, including homelessness?

Terms of Reference: Areas of Enquiry
3. Self Neglect I. Was self-neglect identified as a concern following referrals? II. Was the response to referrals and concerns regarding self-neglect appropriate and timely? III. What consideration was given to CSAB self-neglect procedures and guidance and the legal options which might have been available to protect Sarah from self-neglect? IV. Was the CSAB Escalation guidance considered or applied? What were the barriers for practitioners making referrals regarding concerns about self-neglect?
4. Lack of Engagement & Professional Curiosity I. Did practitioners and agencies consider the impact the death of Sarah's father could have on her mental health? II. Were the methods used to engage with Sarah appropriate to meet her needs at the time? III. What were the barriers and challenges for the practitioners at the time?
5. Communication & Information Sharing I. How effective was the multi-agency working and information sharing around the identification and management of risk, and what challenges did agencies face in achieving this? II. Was consideration given to convening a multi-agency meeting to address the increasing risks in this situation and if so was this timely? III. Was communication with referrer/s appropriate and timely to ensure the referrer was aware of actions, continued risk and outcomes for Sarah?
6. Impact of COVID-19 I. To what extent did the lockdown impact on the provision of single and multi-agency support and safeguarding responses for Sarah?
7. What organisational or partnership systems factors aided or acted as a barrier to effective practice?
8. What good practice was identified?
9. What have been the key points of learning for the agency and what relevant changes have been put in place subsequent to the review scope period

4.1.2. The scope period focused on the period from Sarah's father's death in October 2020 until February 2021, when Sarah's body was discovered. However, the review also took into account information relevant to the terms of reference pre-dating this period.

4.2. Methodology

4.2.1 This Safeguarding Adults Review combined agency reports with a learning event for practitioners who had been directly involved with Sarah. This aimed to explore underlying factors including individual interactions and wider system factors that support or create barriers to good practice.

4.2.2. The CSAB is grateful to Sarah's aunt and uncle for their contribution to this review. Their information helped develop understanding of Sarah and her father and some insights into the challenges they had.

4.2.3. A pseudonym has been used for 'Sarah,' to protect her privacy and dignity. Dates and places have been deliberately generalised.

4.2.4. The role of the contributing agencies is outlined in the table below:

Participating Agencies and Context of Involvement	
Adult Social Care Cumbria County Council	The Adult Social Care (ASC) was involved through referrals and contacts to their Single Point of Access (SPA).
University Hospital Morecambe Bay Trust	University Hospital Morecambe Bay Trust had some involvement in the immediate aftermath of Sarah's father's death, alerting services to her potential vulnerability.
NHS Lancashire and South Cumbria Integrated Care Board and the GP Practice	Provided information relating to involvement of Sarah's GP Practice and the Mental Health Integrated Care Community.
People and Communities Cumbria [redacted] Borough Council	Sarah's father was a tenant of a Borough Council
Cumbria Police	Cumbria Police responded to concerns about Sarah's welfare.

4.2.5. The review also had access to the Coroner's Regulation 28 report and to Cumbria County Council's response.

4.2.6. Safeguarding Adults Reviews should be completed within 6 months of initiating it, unless there are good reasons for a longer period being required.[3] This review was initiated in September 2022, over eighteen months after Sarah's death was discovered and eleven months after the inquest. CSAB decided to delay beginning the review, due to competing demands on agencies from other SAR's and the need to balance learning from reviews with maintaining operational services. The SAR took 9 months from point of the Chair ratifying the decision that criteria for a mandatory SAR were met, through until its conclusion and the final report accepted by the SAR Panel.

4.3 Structure of Report

The report is structured as follows:

- Section 5 provides background and key events relating to agencies' involvement.
- Section 6 gives the context of self-neglect, followed by analysis and learning.
- Section 7 provides a summary of changes made since Sarah's death
- Section 8 offers a conclusion.
- Section 9 makes recommendations for the CSAB and its partner agencies.

[3] Department of Health (2017). Care and support statutory guidance.
[online] Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed December 2021].

5. Background and Key Events Relevant to This Review

5.1. Sarah had always lived with her parents in their Council tenancy. Sarah's parents were in their eighties at the time covered by this review. Sarah had attended a mainstream school but as an adult, became reclusive. Her parents had described Sarah as having schizophrenia. This was never diagnosed as Sarah did not have any contact with mental health services and had not seen her GP in recent years.

5.2. Sarah had not worked for many years and nor did she claim state benefits. She was financially reliant on her parents. Sarah also appeared to be dependent upon her parents for many of her basic tasks of daily living. Her uncle recalled Sarah seldom left the house and was usually dressed in pyjamas.

5.3. Sarah had many episodes of suspected mental health distress. In **2015** neighbours phoned Police. They had heard Sarah shouting and were concerned that there was a domestic abuse incident. Police established that Sarah had been shouting to herself. Her parents told the Police she had an undiagnosed mental illness and that she often behaved that way but was not troubled by it. Police referred to Adult Social Care (ASC) Single Point of Access (SPA) who referred onto Community Mental Health Team (CMHT). The CMHT took no further action other than notifying Sarah's GP Practice of the referral.

5.4. Sadly, Sarah's mother died in 2015.

5.5. In **2016**, Police were called out again by a neighbour. Sarah had been screaming and shouting, throwing items and had smashed a window. Her father told Police that Sarah's aggression had worsened since the death of her mother. Sarah confirmed she was hearing voices, but this was not a problem for her. She did not want any help and did not consent to information being shared. Police referred onto ASC whose mental health duty worker checked she was not known to mental health services and forwarded the referral to her GP Practice, requesting they liaise with Sarah. There is no record of follow up.

5.6. In **2017**, Sarah's father called Police. Sarah had been shouting and slamming doors. He told Police he thought she had mental health issues. Her father talked of struggling to cope with her anger. Sarah presented to the Police as calm and coherent, but Police asked her to leave the house for a period to defuse the tension. Police completed a Domestic Abuse Risk Assessment Checklist (DASH RIC)[4] which rated the risk as standard. Police noted the house was very dirty and untidy. They made a referral to ASC for her father.

5.7. A social worker from the Mental Health division team (Adult Social Care) phoned her father. He felt things had settled down and confirmed he was able to manage independently so ASC advised him he could contact them again if anything changed.

5.8. In **November 2019**, a Housing Benefit Officer made a Safeguarding Adult referral on behalf of Sarah's father. They were concerned about violent outbursts amounting to physical/mental abuse and financial exploitation by Sarah to her father. A Section 42 Safeguarding Adult Enquiry[5] was initiated and he and Sarah were visited at home by a practitioner.

5.9. Her father confirmed difficulties in living with Sarah but no physical violence from her so far. He said he did most household tasks but was struggling because of his physical health. Sarah was living off his income as she would not work and refused to claim benefits. He could no longer afford to pay for everything. Sarah was given advice about how to claim benefits (although her father expressed doubt about whether she would follow this up). Follow up was provided through an Occupational Therapy referral, equipment, and a referral for a benefits check.

[4] https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf
[5] Section 42 of the Care Act 2014 gives Local Authorities the primary duty to make, or cause to be made, whatever enquiries are necessary to enable the Local Authority to decide whether any action should be taken in the adult's case, and if so, what and by whom.

5.10 In **March 2020**, Sarah's father phoned the Police again. There had been a dispute between Sarah and her father and Sarah was alleged to have spat at her father. [This incident occurred at the beginning of the Covid 19 pandemic]. Sarah was arrested and interviewed on suspicion of common assault. The DASH-RIC rated the risk as standard. Sarah did not disclose any vulnerabilities on her custody risk assessment so was not seen by healthcare during her detention. She was offered to be seen by the Liaison and Diversion team (as is the case for all women) whilst in custody but declined. Sarah returned home. Sarah's father did not want to pursue a prosecution against her, saying he simply wanted her to get some help with her declining mental health.

Summary of Events from 2020

5.11. Sadly, Sarah's father died in October 2020. Housing became aware of his death on the day he died via a third party, as her uncle had been seeking advice. Sarah had declined any contact with her aunt and uncle. They were worried about how she would cope, describing her as having mental health problems, that she had been dependent on her father's support and had no income. Housing began to make enquiries with other agencies.

5.12. The hospital had also become aware of concerns about Sarah. When their bereavement officer contacted Sarah to inform her of her father's death, Sarah seemed to have difficulty comprehending he had died. They made further follow up enquiries with Sarah's aunt and learned of their concerns about her. This was escalated to the Hospital Safeguarding Team who requested Sarah's GP carry out a welfare check.

5.13. The GP Practices' Safeguarding lead attempted to contact Sarah that day and again the following day but got no response. Sarah's uncle phoned the GP Practice to talk about their concerns. Sarah's GP tried to contact ASC, leaving a voice message. [There is no further record about this.]

5.14. The hospital Safeguarding team had also contacted ASC -Single Point of Access (SPA). The SPA advised that they would not visit without consent unless Sarah was at immediate risk. Sarah's uncle phoned ASC the following day to discuss his concerns about Sarah. Sarah was continuing to refuse help. The SPA advised him that there were no grounds to override Sarah's consent and suggested her uncle contact Sarah's GP.

5.15. Meanwhile, Housing had been trying without success to contact Sarah –phoning, calling at the house and leaving a card. They had sourced Sarah's GP and were aware her GP had also been trying to contact Sarah.

5.16. A week later, Sarah's uncle contacted ASC-SPA again. The SPA officer advised that as Sarah was still not consenting to a referral, her uncle could 'contact GP as he can act in Sarah's best interest even without her consent.' They also advised her uncle that he could contact Housing. The case was not discussed with the duty social worker.

5.17. Sarah's aunt did contact Housing, reiterating concerns that Sarah could not cope and that they believed she had schizophrenia. The aunt had been leaving food at her front door, but Sarah was refusing any contact and ASC had declined follow up without her consent. Housing contacted her GP Practice to share information they had.

5.18. In early November 2020, the local Police Community Support Officer (PCSO) became involved. Neighbours were concerned that Sarah was unkempt and had been going to the local shops in her pyjamas. The Police safeguarding team checked if Sarah was known. They noted the earlier incident in the year, as well as incidents in 2016 and 2017. Police scheduled a welfare check for the following week.

5.19. Sarah's aunt phoned the Police before this welfare visit was carried out, worried about Sarah. A Police officer visited Sarah at home. She was clear that she did not want any contact with her family or with services. However, Police felt concerned about her self-care and the conditions of her home, so made a referral to ASC, describing concerns of self-neglect and requesting an assessment.

5.20. The ASC SPA tried to make phone contact with Sarah on three occasions that day and then followed up with a letter, notifying Sarah they were closing the referral. There is no record this was re-triaged before closure.

5.21. A week later, the GP Practice contacted ASC for an update. ASC informed her GP of the unsuccessful attempts to make contact. The GP Practice also contacted Housing and provided the background information about Sarah i.e. that they had had no contact in recent years and that Sarah had no known mental health history. Sarah's uncle had phoned the GP to update that the Police had seen her at home. Her uncle described feeling 'really stuck on where to go'.

5.22. At the beginning of **December 2020**, the Housing officer made a phone referral to ASC but the referral was declined as Sarah had not consented. Housing requested Police carry out a welfare check. The Housing Officer also made a referral to the Local Focus Hub[6] to discuss a way forward.

5.23. A PCSO made a welfare visit to Sarah at home. Sarah denied needing any help and assured the officer she would respond to the Housing Officer. The PCSO gave this feedback to the Housing Officer and offered a joint visit. Housing kept the GP updated.

5.24. Sarah's circumstances were discussed at the next Local Focus Hub meeting although the Housing Officer was not aware of this or the outcome.

5.25. Sarah's GP referred the concerns about her to the [Borough] Mental Health Integrated Care Community (ICC).[7] This was attended by representatives from ASC, voluntary sector, Health, Housing and Police although unfortunately no one from the GP Practice was able to attend and nor was the Housing Officer who had been involved. Attendees discussed recent concerns about Sarah. The follow up plan from this meeting is not clear. The GP records note a plan for the Carer's Association to provide the GP with the uncle's contact details. ASC records note the plan was for the GP to discuss with Sarah, a referral to ASC.

5.26. The minutes of the meeting were uploaded onto Sarah's GP record, but this was not flagged to the GP Practice. No agency had any further attempts to contact Sarah. Sarah' aunt and uncle continued to go to the house to see if there were any signs of movement.

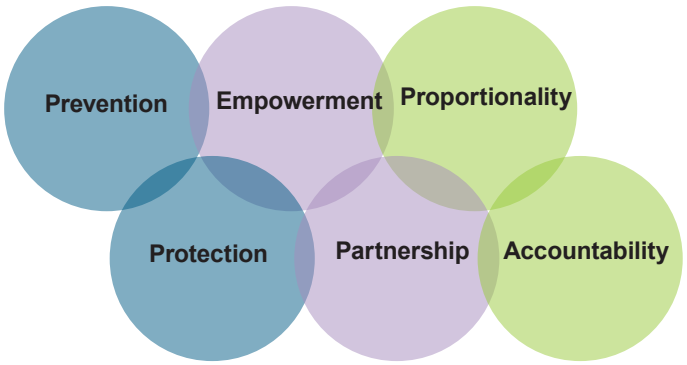
5.27. In **February 2021**, approximately two months after the ICC, Police discovered Sarah's body when they had forced entry to her home in response to concerns that she had not been seen. It appeared that Sarah had died some weeks earlier.

[6] The Local Focus Hubs are set up by the Police to provide a partnership approach to solving problems in the community; based on neighbourhood policing guidance.

[7] The purpose of the [Borough]Mental Health ICC meeting is for GP Surgeries to refer patients with challenging and complex mental health needs to an additional platform to facilitate information sharing, explore any concerns and co-ordinate a multi-agency response. It is aimed at patients with known mental health needs.

6. Analysis and Learning

The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity.[8] The analysis and learning from this SAR is structured around these principles.



6.1. Prevention

6.1.2. The review considered whether there were earlier opportunities to engage Sarah in services and to provide support to her parents as carers.

6.1.3. Sarah's family described her as having undiagnosed mental illness – referring to schizophrenia or a personality disorder. However, the nature and degree of Sarah's mental health difficulties remains unknown as no formal assessment was ever carried out.

6.1.4. Sarah had not been seen by her GP Practice for many years. The Practice had no information to suggest she had mental health needs or a learning disability. Sarah had no known health conditions and was not flagged as being in a vulnerable needs health group that would have triggered more regular contact.

6.1.5. It appears that Sarah had consistently rejected any help from agencies so was unlikely to be proactive in seeking support for herself. Sarah's father was seen periodically at the GP Practice but had not talked of his concerns about Sarah. The reasons for this are not clear. Sarah's uncle thought that her father felt he just needed to get on with it and manage on his own. He had never really talked about Sarah's needs, would not identify himself as a care giver or know what help might be available for her or for him.

6.1.6. Informal carers represent approximately 10% of the population in the United Kingdom and can play an essential role in supporting adults with care and support needs. However, research highlighted that the majority of carers take years to recognise their role as carers, missing out on crucial financial, practical and emotional support in the meantime.[9] The additional stigma that still surrounds mental illness, may increase the risks of carers remaining hidden. Changing demographics of an ageing population means that carers are increasingly older, often struggling with their own complex care needs. Services therefore need to be proactive in reaching out to carers.

6.1.7. Local Authorities and health bodies have a duty to work together to identify carers.[10] NHS England published a paper in 2016, committing to supporting the identification, recognition and registration of Carers within primary care.[11] This should lead to person centred planning, including identifying vulnerable carers, for example, due to age, and providing additional preventative support.

[8] Department of Health Care and Support Statutory Guidance: Issued under the Care Act 2014, (updated January 2022) Available from: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed: October 2022]

[9] Carers UK Missing Out The Identification Challenge 2016 www.carersuk.org

[10] Department of Health Care and support statutory guidance, Paragraph 2.35 https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

[11] NHS England (2016) An integrated approach to identifying and assessing carer health and wellbeing https://www.england.nhs.uk/wp-content/uploads/2016/05/identifying-assessing-carer-hlth-wellbeing.pdf

6.1.8. It may be that Sarah's objection deterred her father from seeking help from Health and Social Care. Sarah's uncle recalled that Sarah had hit her father in the past and he had become more nervous about challenging her after this. The chronology indicates that it was only at point of crisis that Sarah's father sought help, and this was through the Police.

6.1.9. Police appropriately completed DASH-RIC[12] in 2017 and 2020, which rated risk as standard (current evidence does not indicate likelihood of serious harm). They also identified the potential vulnerabilities of her father and made onward referrals for support.

6.1.10. Looking at the pattern of incidents from 2015, there is reference to increasing levels of aggression and Sarah's father struggling to cope. Data from Domestic Homicide Reviews highlights that approximately 30% of perpetrators of the homicide had mental ill health. 8% of the victims were carers. In 60% of these cases the homicide was carried out by a person being cared for. None of the victims with a caring role had received a carer's assessment of their support needs connected with their role as a carer.[13] Further assessment was needed of Sarah and her father, to establish if there was carer stress and the potential for domestic abuse including coercive control.

6.1.11. Contributors to the review identified that this picture of escalating stress and vulnerability within Sarah's household was not well understood or responded to by Health and Social Care agencies.

6.1.12. Sarah's GP noted that in 2016, there was no follow up by the GP Practice to the request from ASC to review Sarah. They reflected that there was no robust system within their GP Practice at that time to ensure responses to communications from partner agencies. Changes made by the GP Practice are summarised in section 7.

6.1.13. Agencies missed other opportunities in the incidents of 2017, 2019 and March 2020 to recognise escalating carer stress and to try and understand more about the reasons for Sarah's behaviours, including potential mental health needs.

6.1.14. ASC did offer support to Sarah's father in response to the 2017 referral from Police. However, there was no liaison with Sarah's GP to check any mental health needs or to alert the GP to the concerns raised by Police.

6.1.15. There is no reference in ASC's response to the 2019 S42 Safeguarding Adult Enquiry, that the previous three incidents had been considered in the decisions made. Again, the GP was not informed of the safeguarding concerns for Sarah's father, nor of her father's concerns about Sarah's mental health. Had the GP Practice been aware of the vulnerabilities within the household, they could have provided a valuable safety net, e.g. using any opportunities to offer follow up support/carer assessment to her father, and trying to make further assessment of Sarah's mental health.

6.1.16. Police had also not been notified of the Safeguarding Adult Enquiry of 2019, so were not able to contribute information, nor to factor this into their decision making and DASH-RIC assessment, when called out again in March 2020.

6.1.17. Sarah was not seen during her period in custody by any health professional. Due to the Covid pandemic, the mental health Liaison and Diversion team were not attending custody and were reliant on Police to identify people that may need further assessment via a telephone triage assessment. Sarah was offered a referral to the Liaison and Diversion team but declined. The escalating picture of aggression and disturbed behaviour by Sarah, and vulnerabilities of her father was not known and no information was shared, or referral made to other agencies.

[12] SafeLives Dash risk checklist for the identification of high risk cases of domestic abuse, stalking and 'honour'-based violence https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf [Accessed October 2022]
[13] HM Government; Home Office Research and analysis Key findings from analysis of domestic homicide reviews March 2022 https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews

6.1.18. The Care Act 2014 section 2, recognises the importance of actions that prevent, reduce or delay needs. 'It is critical to the vision in the Care Act that the care and support system works to actively promote wellbeing and independence and does not just wait to respond when people reach a crisis point.'[14]

6.1.19. Ultimately, these missed opportunities for earlier engagement and assessment, meant that there was no clear picture of what Sarah's needs were, and no contingency planning to support Sarah when her father was no longer able to do so.

Recommendation 1

6.2. Empowerment

6.2.1. Making Safeguarding Personal (MSP) should be a bedrock of Safeguarding Adult practice. It is underpinned by the Mental Capacity Act that sets out the rights of a capacitous adult to make decisions over their lives including their safety and wellbeing, even where those decisions may appear to others to be unwise.

6.2.2. The policy direction toward MSP, rightly sought to rebalance paternalistic practices that left many adults feeling that Safeguarding was a process that was 'done to' them without necessarily improving their lives.[15]

6.2.3. There is however a danger that MSP can be misconstrued and negate practitioners' duty of care. MSP can be inadvertently used to screen referrals out of services without understanding the wider picture of the adult's circumstances.

6.2.4. Working with people who are self-neglecting and resistant to services is complex for practitioners. A review of Safeguarding Adult Reviews in England[16] highlighted that self-neglect was the most common concern that had led to the review being held, accounting for 45% of all reviews.

6.2.5. The Association of Directors of Adult Services cautioned Local Authorities against a 'superficial understanding about Making Safeguarding Personal,' and provided guidance 'to caution those who interpret this approach simplistically.'[17]

6.2.6. A clear message is that MSP doesn't mean walking away.MSP does not abdicate responsibilities to:

1. Assure that an adult has sufficient information to make a decision.
2. Assure the adult's decision making is not impaired by mental capacity, coercion, or undue influence and
3. Practitioners must take reasonable and proportionate steps to engage with the adult towards risk reduction

6.2.7. This review has highlighted significant learning in relation to these factors.

[14] Department of Health Care and Support Statutory Guidance issued under the Care Act 2014 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf
[15] Department of Health: 2009 Safeguarding adults: report on the consultation on the review of "No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse" https://www.scie-socialcareonline.org.uk/safeguarding-adults-report-on-the-consultation-on-the-review-of-no-secrets-guidance-on-developing-and-implementing-multi-agency-policies-and-procedures-to-protect-vulnerable-adults-from-abuse/r/a11G00000017uarIAA
[Accessed October 2022]
[16] Local Government Association: Analysis of Safeguarding Adult Review April 2017- March 2019; October 2020 https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019 [Accessed October 2022]
[17] LGA and ADASS Myths and realities about Making Safeguarding Personal 2019 https://www.local.gov.uk/sites/default/files/documents/25.144%20MSP%20Myths_04%20WEB.pdf [Accessed October 2022]

6.2.8. Although the Police, who had seen Sarah, questioned whether she had the mental capacity to make decisions, the fact that she had not consented became a barrier to further involvement from ASC. It seems that ASC were working on the presumption of capacity (as defined by Principle 1 of the Mental Capacity Act). However, contributors to the review, questioned whether Sarah had been given sufficient information to enable her consent i.e. information that Sarah may attach significance to, about the nature, purpose and consequence of support available[18] There was also pointers that should have led practitioners to question Sarah's capacity, and led to formal assessment, as guided by the Mental Capacity Act Code of Practice.[19] There was questions raised about Sarah's mental health and behaviours, in addition to the concerns expressed by her aunt and uncle.

6.2.9. There was also some misunderstanding by an ASC-SPA officer of the law in relation to capacity. Advice given to Sarah's aunt was to contact her GP as ''he can act in Sarah's best interest even without her consent.' This lack of understanding about the duty of all to act in best interest (where the adult lacks relevant capacity), indicates a need for further training around Mental Capacity Act and MSP as well as greater oversight of SPA officers' decisions by qualified practitioners. The section on 'Accountability' below, discusses this further.

6.2.10. Research has highlighted that taking time to develop a relationship with an adult who is self-neglecting, is a primary factor in improving outcomes.[20] It is key to understanding the reasons behind an adult's self-neglecting behaviours and developing a purposeful relationship that can effect change. Even had practitioners believed Sarah had the capacity to decline services, there was a need to use professional skills to reach out and engage with her.

6.2.11. There were multiple attempts made by different agencies to contact Sarah. There were some examples of good practice, such as from the Housing Officer and from the Police, where different approaches were tried, including home visits.

6.2.12. The ASC author reflected on the 'power of the door knock' in building rapport as well as being able to assess the person within their environment. ASC recognised learning for their service in relation to this. ASC had attempted to phone Sarah in response to a referral from Police, but when no response was given, sent a letter that read:

'Adult Social Care has received an enquiry regarding yourself. Following this enquiry we have tried contacting you by telephone on several occasions to discuss this further but have been unsuccessful. As we have been unable to contact you we will now close your case to Adult Social Care.'

6.2.13. There was nothing about the tone or content of the letter to suggest the SPA officer had considered how best to encourage Sarah's engagement with ASC. Despite the referral from Police raising concerns of self-neglect, the letter was simply a transactional letter informing of closure.

6.2.14. There was also learning about how well agencies involved Sarah's aunt and uncle. The chronology charts them making at least nine contacts to different professionals, to try to convey their concerns and access help for Sarah.

[19] Mental Capacity Act Code of Practice Ch 4.35 Department for Constitutional Affairs, Mental Capacity Act 2005 Code of Practice 2007 https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice [Accessed October 2022]
[20] SCIE (2014), Self-neglect Policy and Practice: Building an Evidence Base for Adult Social Care, Available from: http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/ [Accessed: October 2022]

6.2.15. Sarah's aunt and uncle had no knowledge of what they should expect from services. They were tenacious in trying to navigate their way around services, but their experience was of an impenetrable and frustrating system. This was at a time when they were grieving the very recent death of their brother/ brother-in-law. Sarah's uncle felt ASC should have done more. He described how distressing it was for him and his wife, calling daily to check lights were on or speak to neighbours as Sarah wouldn't let them in. They had posted money through the door for food and left food parcels but didn't know if Sarah was taking them in. He described feeling helpless and seeking help from the Police as a last resort. While different professionals from Hospital; GP Practice, Housing and ASC had listened to them, it was unclear to them who was coordinating the response, what the next steps were or what role they could play.

6.2.16. ASC reflected that services sometimes talk about having a 'strong and robust front door' when what is needed is an open door. They recognised the need to be responsive to people in the midst, respecting that they may seek help through different routes. ASC should not create barriers to this.

Recommendation 1

6.3. Protection and Proportionality

6.3.1. The chronology tracks the responses from professionals in the initial days and weeks following the death of Sarah's father and concerns being raised by Sarah's aunt and uncle.

6.3.2. What was apparent was that there was an initial high level of response from professionals when concerns about Sarah were first raised. There was evidence of some good practice from practitioners in those immediate responses. One example was the Hospital bereavement officer. They demonstrated professional curiosity and safeguarding minded practice in Sarah's response to the news of her father's death. The response by the hospital safeguarding team and the timely contact made by the GP Safeguarding lead, were all examples of good practice.

6.3.3. Similarly, there was good practice demonstrated by the Housing Officer, recognising Sarah's vulnerabilities. Although Sarah was not their tenant, they met their safeguarding responsibilities, making further enquiries, being tenacious in trying to engage with Sarah and alerting others to the concerns. (This is discussed further in the following section on 'Partnerships.')

6.3.4. The Police also provided an effective welfare response. They were attuned to hearing concerns from the neighbourhood, and were proactive in visiting Sarah at home and making onward referrals appropriately.

6.3.5. As noted, Sarah's uncle felt ASC should have done more. Following one contact from Sarah's uncle, the ASC duty Social Worker had recorded within their decision not to accept the referral 'Sarah may not have been independent previously but may develop skills.' This appeared to be optimism without any clear evidence to support it. There are great benefits in taking a strengths-based approach to practice, but this must be founded on evidence-based assessment to avert over optimistic assumptions that may leave an individual at risk. The dangers of the 'Rule of Optimism' have been well documented within Safeguarding Children reviews.[21]

6.3.6. ASC felt that there had been an episodic approach to the referrals made. What emerged during the review was that ASC officers and practitioners had not accessed all the information about earlier incidents. There were two records within the electronic recording system for Sarah and her father. Information recorded from some of the incidents during 2015 – March 2020, was recorded only within Sarah's father's record although both he and Sarah were involved. This information was not accessed in response to concerns about Sarah following her father's death, so this historic context was not visible to inform decisions.

[21]Haringey Safeguarding Children Partnership Key Messages for Practice https://haringeyscp.org.uk/p/professionals/key-messages-for-practice [Accessed October 2022]

6.3.7. There was also reason to question the resilience of systems for recording referrals and contacts into the ASC-SPA. ASC had no record of a phone referral made by Housing in December 2020, nor of a voice message left by Sarah's GP. Section 7 outlines changes that have been made.

Recommendation 1

6.3.8. Reviews must be cautious to avoid hindsight bias. However, the ASC author felt that even with the information that was known, this should have led to further enquiry through a home visit. ASC had received six contacts/referrals from professionals and family within a month. ASC acknowledged the need for their service to have demonstrated greater professional curiosity.

6.3.9. There were many unanswered questions about Sarah's level of dependency, the impact of the bereavement of her sole carer, concerns about self-care, her ability to access any funds, her risk of homelessness, the nature of her mental health and any risks she may present to herself or others.

6.3.10. The indicators were there to signal potential Care Act eligible areas of need. This required evaluation through a full assessment of need, including capacity assessment, risk assessment, and consideration of whether a S42 Safeguarding Enquiry was indicated.

6.3.11. There seemed to be a lack of viewing the information as risk of self-neglect, despite the referral from Police clearly highlighting this as a concern. The ASC safeguarding contact form that was completed answered 'no' to the question of whether a safeguarding concern had been raised. There was no follow-on plan if Sarah did not engage. There appeared to have been no professional assessment of the likely trajectory given her lack of engagement and reported inability to self-care. There was no evidence that the Cumbria self-neglect guidance had been taken into account.[22]

6.3.12. In exploring potential reasons for this, ASC felt there was a systemic issue. Resources were stretched, exacerbated by the Covid Pandemic, and there was a high volume of referrals. Self-neglect was commonly raised by referrers as a concern, but the term was often used loosely without information about the nature or degree of the self-neglect or how this was impacting on the adult or others. Within this context, there is a risk of practitioners becoming blunted – hearing the words but missing what is being said. Professional leadership and supervision is essential to keep this focus on evidence based practice and defensible decision making.

Recommendation 1

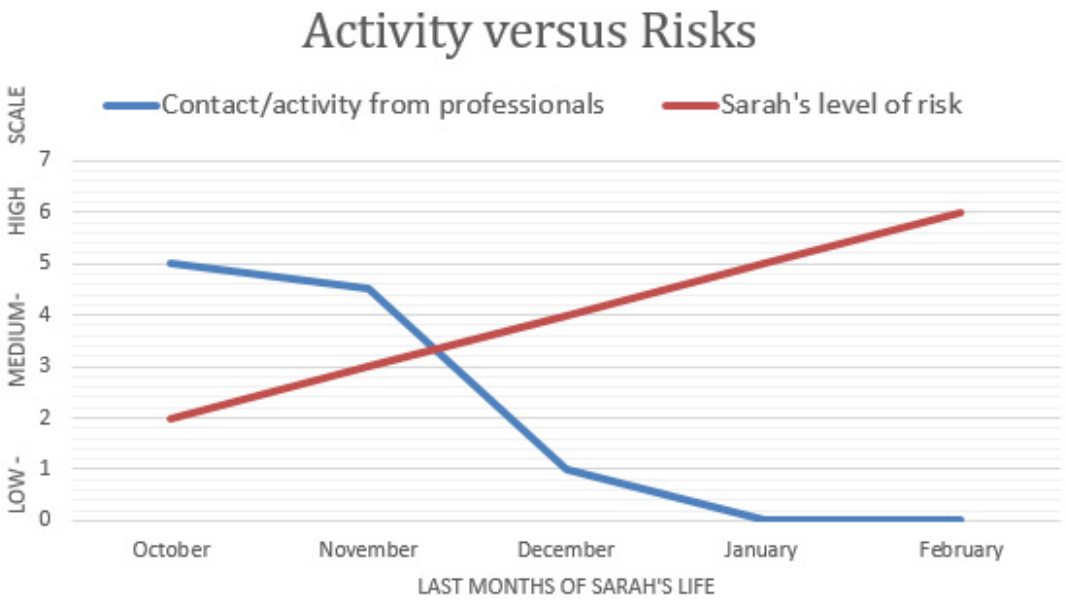
6.3.13. A recurrent message from SARs is that lack of engagement does not equate to lack of risk. This message is repeated here.

6.4. Partnership

6.4.1. Agencies reflected that there was an absence of a coordinated plan between the agencies and no identified lead. In the absence of this, the initial intensive response by different agencies drifted. Meanwhile, the chronic nature of Sarah's lack of self-care, meant the risk to her health and wellbeing escalated.

[22] Cumbria Safeguarding Adult Board Safeguarding Adults Self Neglect Guidance October 2021 https://www.cumbria.gov.uk/eLibrary/Content/Internet/327/949/43214103754.pdf [Accessed October 2022]

6.4.2. The graph below depicts the steadily increasing risks to Sarah (red line) and the broadening gap between this, and the level of activity from professionals (blue line).



6.4.3. There had been pockets of good joint working between agencies. This was demonstrated in the liaison between Housing with Police and with Sarah's GP.

6.4.4. The responsiveness by the Police to the Housing Officers concerns about Sarah's welfare was good partnership working. However, it gives rise to a bigger question of whether this was a reasonable role to ask of the Police in these circumstances. Housing acknowledged that their contact with Police was to try and overcome the block to progressing their referral to ASC without Sarah's consent i.e.using the influence of the Police in referring to ASC. Police were also willing to carry out a home visit for a welfare check. While this may be one route to try and engage people at risk, this needs to be justifiable. Police have no greater powers of access in these circumstances, than any other agencies, (given that there was no information of immediate risk to life or of any potential crime.)

6.4.5. A Police inspection report, Picking Up the Pieces, referenced Police increasingly being called upon to bridge the gaps in services. It referenced 'grave concerns about whether the Police should be involved in responding to mental health problems to the degree they are.' The report acknowledged the valuable role of Police but that their officers may not have the skills required and other professionals may be better placed to respond.[23] Arguably this was the situation with Sarah where an assessment by a social worker/mental health professional may well have been a first step to engagement and making an assessment of any care and support needs.

6.4.6. Housing and Police confirmed that in their experience, the challenges faced in progressing a referral without consent for Sarah, were not unique to her situation. Housing acknowledged a need for their officers to be able to question decisions and use escalation processes where necessary.

6.4.7. The importance of multi-agency working, is a theme in SARs[24] nationally and this review is no exception. It was striking that despite the level of activity from individual agencies in the early weeks following Sarah's father's death, it was not until six weeks later and multiple concerns being raised, that there was any referral for multi-agency meetings. This was action taken by Housing and Sarah's GP.

[23] Her Majesty's Inspectorate of Constabulary and Fire and Rescue Service, Policing and Mental Health, Picking up the Pieces Nov 2018 https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/policing-and-mental-health-picking-up-the-pieces.pdf

[24] Local Government Association: Analysis of Safeguarding Adult Review April 2017- March 2019; October 2020 https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019 [Accessed October 2022]

6.4.8. There were two multi-agency forums where concerns about Sarah were raised. The first was the Local Focus Hub. The Housing Officer had made a referral to try and seek some way forward. Sarah's circumstances were discussed at the Local Focus Hub but there is no record of what was discussed or what the outcome was. The Housing Officer who had made the referral was not aware it had been heard. The Police Safeguarding Hub also noted that although the Local Focus Hub is Chaired by Police, information from that meeting had not been fed back to them. The Hub was relatively newly established and developments are noted in section 7 below.

6.4.9. The second multi-agency forum was the mental health Integrated Care Community. Neither the Housing Officer who had been involved, nor anyone from the GP Practice was able to attend. Whilst there were representatives from key agencies, including Housing, Primary Care, ASC and Police, the information about Sarah's circumstances was limited. There is no evidence to suggest that the magnitude of Sarah's circumstances was acknowledged, discussed or mitigated. The outcomes from this meeting were vague. There was an action for the Carer's Association to provide the GP with the uncle's contact details (although the GP had this already.) Although there had been no recorded action for the GP Practice, ASC records noted that the GP would follow up 'as they had a good relationship with Sarah.' This was inaccurate and misleading.

6.4.10. The lack of a well-communicated plan was evident in the last recorded reference to Sarah by any of the involved agencies. Sarah was discussed one week after the ICC at an in-house monthly safeguarding meeting at the GP Practice. The discussion noted they were awaiting further communication from partner agencies with regards to next steps. The assumption was that another agency was leading the response.

6.4.11. Use of multi-agency forums should be an effective first step in responding to self-neglect and is part of the Cumbria Self-negelct Guidance pathway.[25] However, both these multi-agency forums lacked fundamental requirements:

- Attendees with appropriate skills and knowledge to represent their agency
- Attendees equipped with sufficient information about the circumstances of the case
- Demonstrating safeguarding minded practice – recognising indicators of self-neglect and the need to apply policy and appropriate legal frameworks
- Applying a structured approach to assessing information and agreeing a clear plan (and contingency)
- Assigning a lead coordinator to assure ongoing communication and review.

6.4.12. Very sadly, the lack of a well formulated and coordinated plan meant no agency tried to make further contact with Sarah or with her aunt or uncle.

Recommendation 2

[25] Cumbria Safeguarding Adult Board Safeguarding Adults Self Neglect Guidance October 2021 https://www.cumbria.gov.uk/eLibrary/Content/Internet/327/949/43214103754.pdf [Accessed October 2022]

6.5. Accountability

6.5.1. The sections above have highlighted many learning points in relation to agencies' accountability for effective safeguarding practice. An earlier SAR 'Pauline and George' published by CSAB in 2022, reviewed the deaths of other adults during this same period. Many of the same themes that arose within that review have arisen in learning from Sarah's death, namely:

- A lack of professional curiosity
- Episodic approach to incidents
- Barriers at the front door to ASC
  - i) over-reliance on unqualified staff without professional oversight of decisions made
  - ii) lack of consent inappropriatly being used to screen out referrals without evaluation of all circumstances including risk and assessing capacity where indicated
- Identifying needs of carers
- Lack of investing time for outreach and engagement
- Absence of home visits where indicated
- Lack of robust risk assessments
- Lack of recognition of self-neglect indicators and use of CSAB Self-neglect guidance
- Missed opportunities for information sharing between agencies
- Missed opportunties to refer into multi-agency forums at and earlier stage
- The need for those multi-agency forums to demonstrate effective safeguarding minded practice to achieve a well considered and coordinated response

6.5.2. It is recognised that these incidents occurred during the Covid Pandemic. It is highly likely that the additional pressures on resources and working practices impacted on practitioners. Sarah's GP noted that pre-Covid, it was likely that the GP Practice would have attempted a home visit. The GP Practice also recognised that they could have improved use of systems to support accountable practice i.e. coding Sarah on their system as a safeguarding concern, once the concerns had first been flagged. They also reflected that applying the CSAB Self-neglect guidance would have strengthened their response.

6.5.3. While systems and processes are important to support practice, ASC highlighted some risks of operationalising practice i.e. becoming overly process driven, detracting from the use of professional skills. A pressured work environment makes it more challenging for staff to be professionally curious, taking the time needed to draw out and then follow up on information.[26]

6.5.4. This is the second SAR from that period, that has raised practice issues at the front door to ASC. Individual staff do need to be attuned to hearing information that signals Care Act duties and have clear understanding of policy and legal framework. However, ASC recognised organisational factors that appear to be impacting on the quality of response:

i) the ratio of qualified to unqualified staff and the leadership to support practitioners.

ii) the ability to draw information off the electronic record and cross reference to other relevant records (such as carers), so the whole chronology of incidents can be seen.

iii) A lack of recording systems and operational guidance to identify and respond to multiple referrals

iv) Questions about how robust the systems are for recording and tracking referrals/contacts coming into the service

[26] Burton and Revell 2018 Professional Curiosity in Child Protection: Thinking the Unthinkable in a Neo-Liberal World September 2018 British Journal of Social Work 48(6):1508-1523

6.5.5. At time of the review, Cumbria was in the process of a Local Government Reorganisation process to bring seven boroughs into unitary authorities. This may present an opportunity for a root and branch review of the access point to ASC to ensure this crucial point in the pathway provides the effective and robust response that all would want to see.

Recommendation 1

6.5.6. The SAR 'Pauline and George,' made a number of recommendations for the CSAB and its constituent agencies, in summary:

I. Develop guidance on disguised engagement and professional curiosity

II. Develop self-neglect guidance

III. Improving information flow between agencies (ambulance service and GP Practice)

IV. Ensure lessons from SARs are disseminated

V. Review TOR and documentation used within Integrated Care Communities to ensure safeguarding minded practice

6.5.7. Many of these recommendations are relevant to learning from this SAR. The following section reviews changes already put in place.

7. What Has Changed?

7.1. The CSAB has begun to address the recommendations from the SAR 'Pauline and George' that concluded in May 2022. The CSAB self-neglect guidance has been revised and re-issued, to include further information on referral routes for multi-agency forums for lower-level concerns, recognition of the need for additional time to engage, as well as additional tools to support the assessment and referral process. The CSAB has also published Practitioner Guidance and A Quick Guide relating to professional curiosity and continue to develop tools for practitioners including learning sessions, podcasts, videos and briefings for practitioners and CSAB executive members. The CSAB has also developed a leadership self-assessment tool which will examine supervision and support for practitioners across the system, based on LGA/ADASS Safeguarding Adults Tool.

7.2. ASC has implemented a new system for telephone responses. ASC has also reviewed and revised their operational practice guidance in relation to self-neglect to reinforce that a face-to-face visit must be undertaken to complete assessment and ensure the safety of the person at risk. Work has been carried out with division teams around professional curiosity and the power of the door knock, including adding this in as standing a standing item in supervision and meeting agendas.

7.3. ASC has also established a dedicated Safeguarding Adult team providing support across the county, including advice to the mental health and learning disability teams that are providing the safeguarding response. This aims to ensure a consistent and compliant response for all safeguarding concerns, including concerns of self-neglect. That team is providing training sessions across all partners to embed the review of self-neglect policy, procedure, and guidance. A practice learning session has also been undertaken with the SPA team in relation to responses to self-neglect.

7.4. Sarah's GP Practice has strengthened their systems to ensure that any information shared with the Practice relating to vulnerabilities including mental health and safeguarding is flagged to either the Lead Clinician or the Safeguarding Lead to review and take appropriate action. The Practice has also appointed a Mental Health Practitioner who they can link in with for expert mental health support and guidance.

7.5. In relation to the multi-agency forums, the lead of the [Borough] Mental Health ICC meetings has improved the communication of actions from ICC so that the GP Practice is alerted to minutes and actions from the ICC, in addition to uploading information to the relevant patient record. Nationally, work is underway to develop standards for best practice guidance for information sharing within ICC meetings.

7.6. The Local Focus Hub is now well established and contributors to the review reported it is functioning well. The Police have now ensured that relevant information discussed at the meeting is shared with the Police Safeguarding Hub.

7.7. Housing are amending their internal Safeguarding Adult procedures to ensure follow up where there has been no response to a referral. Staff will also be encouraged to make professional challenge and use escalation processes where they feel a decision is not well founded.

8. Conclusions

8.1. This review has considered the sad circumstances surrounding the death of Sarah. There were earlier missed opportunities to have understand Sarah and her father's circumstances, to offer assessment and support and develop an advanced care plan.

8.2. Sarah's aunt and uncle were relentless in trying to seek help for Sarah following her father's death. Despite efforts by some individual practitioners to mobilise assessment and support, there were barriers to accessing this help that should not have been there. The fact that Sarah had not consented to services being involved was taken at face value. The signals of her needs and risks were not read, the question of her capacity not fully explored and insufficient steps were taken to reach out to her.

8.3. Indicators of self-neglect did not lead agencies to follow CSAB self-neglect guidance. The multi-agency meetings that did occur were ineffectual and did not lead to a coordinated plan. No agency attempted to make further contact with Sarah.

8.4. The main message Sarah's family wanted to convey is the need to be responsive, to get things moving quicker where there are concerns raised and the adult is not answering calls. The review supports their views.

8.5. These sad circumstances were not unique to Sarah. The review reinforces (but does not repeat) the recommendations already made in a previous SAR, and recognises steps taken to improve services since Sarah's death.

9. Recommendations

Recommendation 1: Review of Adult Social care Single Point of Access

Cumbria County Council should carry out a root and branch review of their Adult Social Care Single Point of Access. The review should assure the service has workforce capacity, skills, leadership and support systems to deliver an effective service. The review should benchmark against quality standards, taking account of learning from this SAR and from 'Pauline and George' SAR, along with consulting with services user's and partners, when establishing those standards.

Recommendation 2: Development and Assurance of Multi-agency Forums

Cumbria Safeguarding Adult Board should establish a task and finish group drawn from SAB member agencies, aimed at strengthening multi-agency responses below the threshold of a Safeguarding Adult Enquiry. The work should include:

i) Leading a mapping exercise of multi-agency forums that may be used to support early intervention where lower level or emerging concerns of self-neglect may be discussed.

ii) Generate guidance that:

- Provides a route map to accessing those forums and
- Reinforces key principles when working with self-neglect, (including professional accountability and collaborative multi-agency working at the earliest stage)

iii) The task and finish group should lead targeted work with those forums to ensure they are equipped to make effective responses to self-neglect. This includes setting out expected standards e.g. maximising involvement (Making Safeguarding Personal); gathering information; dynamic assessment; appointing a lead; clear response plan, contingency planning and review, along with recognising where escalation through Safeguarding Adult procedures is merited.

Sylvia Manson
Sylman Consulting
Date: November 2022

Glossary

ASC Adult Social Care

CMHT Community mental health team

CSAB Cumbria Safeguarding Adult Board

DASH -RIC Domestic abuse, stalking and 'honour'-based violence Risk Checklist

ICC Integrated Care Community

LFH Local Focus Hub

MSP Making Safeguarding Personal

PCSO Police Community Support Officer

SAR Safeguarding Adult Review

SPA Single Point of Access

References

Burton and Revell 2018 Professional Curiosity in Child Protection: Thinking the Unthinkable in a Neo-Liberal World September 2018 British Journal of Social Work 48(6):1508-1523

Carers UK Missing Out The Identification Challenge 2016 www.carersuk.org

Cumbria Safeguarding Adult Board, Cumbria Safeguarding Children Partnership, Safer Cumbria: Professional Curiosity Guidance for Practitioners

Cumbria Safeguarding Adult Board Safeguarding Adults Self Neglect Guidance October 2021 https://www.cumbria.gov.uk/eLibrary/Content/Internet/327/949/43214103754.pdf [Accessed December 2021]

Cumbria Safeguarding Adult Board Safeguarding Adults Self Neglect Guidance October 2017

Cumbria Safeguarding Adult Board Safeguarding Adults Threshold Tool February 2021

Department for Constitutional Affairs, Mental Capacity Act 2005 Code of Practice 2007 https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice [Accessed October 2022]

Department of Health Care and Support Statutory Guidance: Issued under the Care Act 2014, (updated January 2022) Available from: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed: October 2022]

Department of Health: 2009 Safeguarding adults: report on the consultation on the review of "No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse" https://www.scie-socialcareonline.org.uk/safeguarding-adults-report-on-the-consultation-on-the-review-of-no-secrets-guidance-on-developing-and-implementing-multi-agency-policies-and-procedures-to-protect-vulnerable-adults-from-abuse/r/a11G00000017uarIAA

Haringey Safeguarding Children Partnership Key Messages for Practice https://haringeyscp.org.uk/p/professionals/key-messages-for-practice

Her Majesty's Inspectorate of Constabulary and Fire and Rescue Service, Policing and Mental Health, Picking up the Pieces Nov 2018 https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/policing-and-mental-health-picking-up-the-pieces.pdf

HM Government; Home Office Research and analysis Key findings from analysis of domestic homicide reviews March 2022 https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews

International Journal of Social Psychiatry Informal Carer in Severe Mental Health Conditions: Issues Raised by the United Kingdom SARS Covid 19 Pandemic Volume 67 May 2020 https://journals.sagepub.com/doi/10.1177/0020764020927046

LGA and ADASS Myths and realities about Making Safeguarding Personal 2019 https://www.local.gov.uk/sites/default/files/documents/25.144%20MSP%20Myths_04%20WEB.pdf [Accessed October 2022]

Local Government Association: Analysis of Safeguarding Adult Review April 2017- March 2019; Executive Summary October 2020 https://www.local.gov.uk/analysis-safeguarding-adult-reviews-april-2017-march-2019 [Accessed October 2022]

NHS England (2016) An integrated approach to identifying and assessing carer health and wellbeing https://www.england.nhs.uk/wp-content/uploads/2016/05/identifying-assessing-carer-hlth-wellbeing.pdf

Research in Practice Professional curiosity in safeguarding adults www.researchinpractice.org.uk [Accessed October 2022]

SafeLives Dash risk checklist for the identification of high risk cases of domestic abuse, stalking and 'honour'-based violence https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf [Accessed October 2022]

SCIE (2014), Self-neglect Policy and Practice: Building an Evidence Base for Adult Social Care, Available from: http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/ [Accessed: October 2022]

Supreme Court ruling of Montgomery and Lanarkshire Health board [2015] UKSC 11 2013/0136https://www.supremecourt.uk/cases/uksc-2013-0136.html [Accessed October 2022]

About the Reviewer

The review report was written by Sylvia Manson, of Sylman Consulting. Sylvia is a mental health social worker by background and has many years experience in Health and Social Care senior management and commissioning. Sylvia has held regional and national roles in implementing legislation and developing safeguarding policy, including as Department of Health, lead for NHS, developing the Safeguarding Adult Principles, now incorporated into the Care Act statutory guidance.

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