Shropshire Safeguarding Community Partnership

Safeguarding Adult Review
Lily

Report Author Lisa Gardner

Contents

1. INTRODUCTION

1.1 Lily is a pseudonym. Lily was 34 years old when she was found deceased at her home following a telephone call to Police by concerned neighbours. Lily lived alone in a town in Shropshire, she was known to several services in the area as she had complex mental health needs.

1.2 Lily's family lived in a nearby county. Whilst producing this Safeguarding Adult Review, her family have been approached and offered the opportunity to contribute, however they have chosen not to be involved in this process. The Partnership fully respect this decision but would remain open to have discussions with them if they were to change their mind.

1.3 Lily had been deceased for some time when she was found by the Police. There was an inquest into Lily's death and the Coroner recorded that she died of "unascertained cause, in unknown circumstances."

2. SAFEGUARDING ADULT REVIEWS

2.1 In Shropshire the Safeguarding Adult Board is known as Shropshire Safeguarding Community Partnership (this is a joint partnership with Children's Safeguarding and Community Safety). Under Section 44 of the Care Act 2014, the Partnership has a statutory duty to undertake a Safeguarding Adult Review if the following criteria is met:

'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 Safeguarding Adult Board, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) the adult had died, and the Safeguarding Adult Board knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the Safeguarding Adult Board knows or suspects that the adult has experienced serious abuse or neglect.

The Safeguarding Adult Board may also –

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 Safeguarding Adult Board 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.

2.2 There is further information about the Safeguarding Adult Review process and how agencies involved in the process should work together to learn lessons and disseminate learning on the Shropshire Safeguarding Community Partnership Website.

2.3 The purpose of a Safeguarding Adult Review is to identify areas for further learning so that we may identify ways of improving service provision. The purpose of a Safeguarding Adult Review is not to apportion blame or establish culpability.

2.4 Lily's death was referred to the Shropshire Safeguarding Community Partnership for consideration of a Safeguarding Adult Review in November 2021. An initial scoping meeting took place in December 2021 and the Safeguarding Adult Review Panel) recommended that the criteria had been met for a Safeguarding Adult Review. The Independent Chair then concluded that the criteria had been met.

2.5 There was some initial learning identified from this scoping meeting which individual agencies agreed to undertake. From this meeting the Terms of Reference were produced [please see section 3.4 below].

2.6 This Safeguarding Adult review has been produced by Lisa Gardner who is a Development Officer within the Shropshire Safeguarding Community Partnership Business Unit. Lisa had no direct involvement in the contacts any of the agencies who worked with Lily had.

3. TERMS OF REFERENCE & SCOPE OF REVIEW

3.1 The period covered by this review is 1st October 2019 until the date that Lily was found deceased in her home by Police on 8th November 2021. During this time period, Lily was known to have stopped engaging with an Independent sector Mental Health Service provision which had been offered to Lily as an alternative to engagement with statutory services. Statutory services struggled to find ways to engage Lily when supporting her.

3.2 The agencies contributing to the review were:

- West Midlands Ambulance Service
- West Mercia Police
- Midlands Partnership NHS Foundation Trust
- South Hermitage GP Surgery
- Severnside Housing (now Homes Plus)
- Shropshire Council Adult's Mental Health Social Work Team

3.3 Methodology

3.3.1 There was a lot of learning identified in the initial scoping meeting, which is included within the body of this report, therefore the terms of reference focused specifically on the areas that needed to be explored further.

3.3.2 All agencies involved were asked to complete a detailed Individual Management Report and Chronology. These reports were submitted to the author and presented by the authors in a meeting so that there was further opportunity for reflection and learning.

3.3.3 Local and national research into identified areas of learning within this review have been reviewed and will be referenced.

3.4 **Terms of Reference**

3.4.1 The specific terms of reference for this Safeguarding Adult Review are:

3.4.2 There is evidence that Lily experienced mental health problems and that this could have contributed to self-neglecting behaviour. What evidence is there in this case that Lily's mental health was understood by the agencies involved? If it was not understood did this have a bearing on how she was supported?

3.4.3 What evidence is there that staff involved in this case had knowledge of and applied the Shropshire Safeguarding Community Partnership's Responding to Self-Neglect in Shropshire Practice Guidance and Working with Risk Guidance in their work with Lily?

3.4.4 What evidence is there (if any) that the Police have received the necessary training on adult safeguarding, including how and when to raise an adult safeguarding concern in accordance with the Care Act (2014)?

3.4.5 Did the Police share concerns about Lily's vulnerability to other agencies in a timely manner?

3.4.6 The Scoping Panel were informed that a review of the Harm Assessment Unit was to be undertaken which would help address issues raised within this review. Can Police colleagues provide assurances about this work and how it will be reported to Shropshire Safeguarding Community Partnership?

3.4.7 On 14.10.19, what evidence is there to support agency decisions to leave Lily at home without a formal assessment of her mental health or mental capacity? If her mental capacity was assessed, given that it is time and decision specific, what was assessed and how was this recorded?

3.4.8 When the Social worker was on annual leave on the 14.10.19 why was there no one available from Adult Social Care to advise when the Ambulance service telephoned the team?

3.4.9 Agency reports submitted note that Lily refused or disengaged from services. There are also frequent references to Lily being informed to seek help if she required it (some of these at times of crisis). Was it ever considered that agencies were overly dependent on Lily doing this and what were the contingencies if she didn't?

3.4.10 Given Lily's preference for writing to agencies rather than speaking to them, how did agencies respond to the written communications they received from Lily (either directly or via other agencies) and how did they act upon any safeguarding concerns that were raised within them?

3.4.11 What evidence is there that when deciding to close Lily's care to services that there was a robust risk assessment in place? In addition, what had been done by agencies to promote and support engagement with Lily and the services that were on offer?

4. COMBINED AGENCY CHRONOLOGY - LILY

4.1 The following is a summary of the time period covered by this review and the interactions that Lily had with agencies during this period.

4.2 Lily's neighbour became concerned for her wellbeing on the morning of 10th October 2019 after she had spent long period of time "shouting and throwing things at the wall" in her property. The neighbour contacted the Police explaining that Lily had mental health issues and that this behaviour was something that happened often. At the time of the call there were no available Officers to attend, however later that day two Police Community Support Officers visited Lily's property on two occasions. Lily did not answer the door on either occasion.

4.3 The following day another Police Community Support Officer visited Lily's property. They noted that there was a light on but there was no response when they knocked on the front door. The neighbour who had raised the original call was contacted and they stated that they were out at present but would call again if they heard Lily when they returned home.

4.4 Later, on the 11th of October 2019 the neighbour called the Police again to say that Lily was alone in her house and "was screaming and shouting".

4.5 A few hours later, in the early hours of the morning on 12th October, the same neighbour called as they could hear Lily shouting "no one fucking cares". No Officers were deployed at this time as it was well documented that this behaviour was a regular occurrence for Lily and there was no information to suggest that she was a danger to herself or others.

4.6 Late morning on 12th October 2019 Lily's neighbour rang the Police again to say that Lily had smashed a window and was "shouting and screaming". A Police Community Support Officer was allocated to attend. Again, there was no reply from inside the property when they arrived, but they did note a smashed inner panel on one of the windows at the front of the property.

4.7 Severnside Housing were concerned about Lily's mental health and wellbeing as they had been informed of the calls to the Police over the previous few days so on the 14th October 2019, they conducted a joint visit to Lily with the local Police Community Support Officer. Lily became distressed by their presence and was refusing any of the support that was being offered by Severnside. Due to Lily's heightened state, an Ambulance was called. The Police Community Support Officer also made a call to the police station to ask for further assistance.

4.8 When the ambulance crew arrived, Lily was verbally abusive and refused all assessments. The ambulance crew documented that Lily had mental capacity. This was based on conversations that took place on the scene with Lily and other agencies present. The Police attempted to get Lily to engage with the Mental Health Access Team (provided through Midlands Partnership NHS Foundation Trust) on the telephone but she refused. The ambulance crew called the Mental Health Social Work Team (provided by Shropshire Council) on advice from the Crisis Team (a service that is also part of Midlands Partnership NHS Foundation Trust) as they did not have an open referral for Lily and it was noted that Lily had an allocated social worker. The Ambulance crew were unable to speak to her Social Worker as she was on annual leave so called the Crisis Team back.

4.9 Those present at Lily's home were advised by the Crisis Team that Lily would often calm down if left and that they would contact Lily via phone in 30 minutes to check on her. The

ambulance crew, Police and Severnside staff left Lily's property as advised by the Crisis Team.

4.10 The Police Officers who attended Lily's home that day recorded an 'Adult Protection Investigation' which was forwarded to the Harm Assessment Unit for consideration. The report was reviewed by the Harm Assessment Unit who decided that no onward referral was required as "Lily had repeatedly refused help and the Crisis Team had advised that they would contact her after 30 minutes, therefore the most appropriate agency was present and aware. No requirement for Police to share this information"

4.11 When the Crisis team attempted to call Lily after 30 minutes, they did not get a response and therefore two mental health nurses attended the property. An ambulance also attended as the neighbour had again called the Police to say that Lily was "chucking things at her window and hitting herself". The Police had called the ambulance as the they felt they were the most appropriate service to respond.

4.12 The Crisis Team and ambulance crew were unable to gain access to Lily's property as she would not answer the door. She was inside shouting and throwing things and then ran upstairs when they knocked on the door. The ambulance crew called the Police for assistance to enter the property but were advised to attempt to persuade Lily to let them in in the first instance and if she began to make threats, then they should call back.

4.13 No observations were taken, and a formal assessment of capacity could not be completed as the Crisis Team nor ambulance crew entered the property. They left after 30 minutes. Lily was upstairs in her property and appeared to be quiet.

4.14 On the 15th October 2019 Midland Partnership NHS Foundation Trust's Crisis Team emailed the Adult Social Care Mental Health Social Work Team to request that they make contact with Lily. The mental health social work team also received an email the following day from Midland Partnership NHS Foundation Trust's Psychosis West Team to say Lily had been allocated for assessment due to her being on Cluster 12. Cluster 12 is a system of different pathways to be used dependent upon the types of presenting problems and diagnosis a person may have. Cluster 12 relates to ongoing and recurrent Psychosis[1].

4.15 Telephone calls were made to Lily, but she did not answer, she was also offered an appointment with Psychosis West Team for an assessment of her mental health, however Lily did not attend this appointment.

4.16 On the 31st October 2019 Lily attended a Local Police Station saying that she wanted to report historical mental and physical abuse by family members; she was very distressed. Lily wanted to speak to a Police Officer however there was not one available to speak to her at that time. The front desk clerk spoke with Lily and arranged a diary appointment for Lily to attend the Police Station on 2nd November 2019 when she would be able to talk to a Police Officer.

4.17 An Officer called Lily on the phone on the evening of the 2nd November 2019, she seemed confused (no further details were recorded). The Officer then attended her property, she did not answer the door and instead spoke to him through the window. Lily told him to go away, he explained he was there because of the report she had made at the Police Station. Lily said she did not know what he was talking about and repeated that she wanted him to go away.

[1] ADULT MENTAL HEALTH CARE CLUSTER CODE (datadictionary.nhs.uk)

4.18 The Officer recorded on an incident log that Lily had been safe and well and therefore he had no powers of entry. He also recorded an “Adult Protection Investigation” as Lily seemed “very confused on arrival and did not wish to speak to Police. She has obvious mental health and learning difficulties”. An adult risk assessment was recorded as medium risk. This was because although she was seen safe and well, there was broken glass in the window and the living room was scattered with litter.

4.19 The incident was flagged with the Harm Assessment Unit who shared the following information with Shropshire Council’s Adult Safeguarding and Midland Partnership NHS Foundation Trust, “Lily has care and support needs requiring practical, financial or emotional support for adults who need extra help to manage their lives and be independent”.

4.20 On 6th December 2019 Lily was closed to both Psychosis Pathway West and Adult Social Care’s Mental Health Social Work Team as neither had been able to find a way to engage her in either assessment or services that they could provide. The GP was informed of these closures by letter.

4.21 In March 2020, Shropshire Council’s Mental Health Social Work Team were notified by Severnside Housing that Lily was refusing to allow them entry to the property to carry out property compliance checks. Due to this and their concern about damage to property, they asked for support to engage Lily to prevent the need to go to court to gain access or potentially seek possession.

4.22 Between 5th March 2020 and 20th November 2020, several members of the Mental Health Social Work Team attempted to make contact with Lily using a variety of communication methods. They did this in conjunction with a member of Severnside Housing Compliance Team. In total there were 5 telephone calls, 8 text messages, 9 visits to the property and 3 letters sent to Lily.

4.23 Also, during this period, (25th April 2020) the Police received a 999 call from Lily’s neighbours reporting that Lily was having a “meltdown”. She was throwing things through the window and the neighbour could hear things being smashed in the property. When Police Officers arrived at Lily’s property, she refused to allow them in and was shouting that she wanted to be left alone. Lily moved to the back of the property meaning that Officers could not see her. This caused them concern for her safety due to her heightened state of agitation and distress. One Officer climbed up onto the balcony of the property and could see into the bedroom. There was broken furniture, splintered wood, and general untidiness. Lily opened the patio doors to engage with the Officer, so no forced entry was required.

4.24 West Midlands Ambulance Service was also on the scene during this time. Lily told the Police Officer that she did not want to be checked by the ambulance crew. Lily said she had no intention of hurting herself and that she did not want any help from the Police. The Crisis Team were called but Lily did not wish to speak to them at that time. An “Adult Protection Investigation” was flagged for the Harm Assessment Unit who decided: “no referrals required; Lily did not wish for any assistance. No suggestion or indication she is mentally unwell. No details of any support workers for her, she has details of the Crisis Team if needed”.

4.25 On 8th September 2020 Lily contacted Midland Partnership NHS Foundation Trust’s Access Team as she was upset and distressed. She had wanted to speak to the Crisis Team but was told that she was not open to them and therefore needed to speak to the Access Team. Reluctantly Lily agreed to this and when she was called back an hour later, she explained that she was not suicidal or self-harming. She was asked to answer

some more questions, but Lily refused to do so saying she did not want to talk anymore, and she put the phone down. Several attempts were made to call Lily back and a text message was sent asking her to make contact if she wished to continue with her referral for mental health services. Further attempts were made to call Lily and she answered saying she did not want to talk about anything.

4.26 The Access Team tried again to contact Lily to see if she would like to talk to them however there was no response to their call. They sent a letter to her home address on 9th September 2020 requesting contact within the next seven days.

4.27 On 15th September 2020, the Mental Health Social Work Team received a 25-page double sided A4 handwritten letter from Lily. This letter contained extensive information about Lily, her friends, and her family, however it was difficult to understand as it did not appear to be in order and was 'erratic'. It contained allegations against named people and disclosures of abuse that Lily had suffered. It also asked that someone do something to help her family who lived in a near-by county. A copy of this letter was shared with the Access Team.

4.28 On the 17th September 2020, two Mental Health Social Work Team workers went to visit Lily at her property. They informed her that they had made the necessary referrals to help her family and that these had been accepted. Lily did not verbally respond in anyway. She sat cross legged on the floor writing in a notebook. The workers continued to try and engage with Lily through the window however this was to no avail.

4.29 On the 20th September 2020, a Police Community Support Officer was dispatched to Lily's address as there had been a concern for welfare call made on the 16th by a neighbour who said that they had not seen her for several days. When the Police Community Support Officer arrived, she found the back door open and entered to find Lily lying on the sofa. Lily looked like she had been sick but said that she was ok and did not want the Police Community Support Officer there. The Support Officer left and no 'Adult Protection Incident' was created.

4.30 Between 23rd September 2020 and 16th February 2021, there were continued joint attempts by the Severnside Housing Compliance Officer and Shropshire Council's Mental Health Social Work Team's Support Worker to try and communicate with Lily and gain entry to the property. This included weekly visits. This was due to safety checks and an inspection of the property needing to be carried out.

4.31 Due to the communication with Lily by Severnside and the Mental Health Social Work Team having been unsuccessful, court proceedings paperwork was filed on 3rd March 2021. This had been delayed due to COVID 19. On the 19th March 2021, the Court confirmed that Severnside could force entry to the property to complete safety checks and complete any work that was required.

4.32 On the 16th April 2021, the Compliance Officer hand delivered a copy of the Court Order to Lily (a copy was also posted). Weekly visits to Lily's property also continued. On 28th April 2021, the Compliance Officer explained the Court Order and what it meant, to Lily through her window. It was explained to Lily that the date had been set for them to enter the property and that if Lily did not allow them in, then they would have to force entry to the property. Lily did not respond to any of the dialogue.

4.33 On 28th April 2021, the Compliance Officer returned with an electrician who was going to install the isolator switch fitting. Entry to the property had to be forced. Lily was disturbed by this and shouted at the workman. When she calmed down, she went upstairs. The Compliance Officer sat on the stairs and explained everything that was

happening to Lily as it was happening, this seemed to calm Lily and she responded reasonably.

4.34 Prior to any work being done, the Compliance Officer and Mental Health Support Worker would visit Lily to prepare her for it. On the 13th July 2021, Lily let in the Compliance Officer and an electrician. The Compliance Officer described this as 'the best she had seen Lily, she advised of issues that needed repair, allowed the electrician to go upstairs and take pictures of damp issues from a leak, and agreed to them sending someone to do these repairs. Lily was reasonably communicative throughout the 3-4-hour visit'.

4.35 On the 29th September 2021, the Compliance Officer visited Lily's property with an operative to measure the window that needed to be replaced. Lily asked them not to go into the property as her mental health was bad. The operative said he could measure the window from outside. Lily said that was ok, the window was measured, and they left.

4.36 On the 8th November 2021, the Police received a call from Lily's neighbour saying that they had not heard or seen her for a while. They had walked past her property yesterday and there were flies in the window and an awful smell. Police attended the property and found Lily deceased. It appeared that she had been there for some time given the level of decomposition. The conditions of the property were described as poor with food containers and half-drunk sugary drinks on the floor next to her body. There were also full buckets of fluid which officers believed to have been vomit or urine.

5. EVIDENCE BASE

Mental Capacity Assessments

5.1 There has recently been a Safeguarding Adult Review published in Shropshire and there is another that is being conducted whereby the understanding of mental capacity and the carrying out of capacity assessments has been identified as a point of learning. Michael Preston Shoot (2018)[2] noted criticism of Mental Capacity Assessments as a general theme in Safeguarding Adult Reviews more widely. In a number of the cases Preston-Shoot reviewed, the practitioners carrying out the assessments did not record the specific decision for which the individual's capacity to make that decision was being assessed. There was a lack of consideration for the impact of an impairment of executive functioning and at other times capacity was assumed.

5.2 Preston-Shoot (2018) goes on to say that "*Sometimes assessment was insufficiently robust, perhaps because practitioners lack confidence in their knowledge and skills, and in taking best interest decisions. Assessment must be contextual, cognisant of relationships surrounding the individual and include triangulation with the known information, for example, a person's mental health history".*

5.3 The Responding to Self-Neglect in Shropshire[3] Good Practice Guidance and Local Procedure states clearly that *"The expectation of the SSCP is that all organisations to whom this document applies should ensure that there is a sufficient understanding and ability to apply in practice the Mental Capacity Act 2005 and associated Code of Practice at all levels of their organisation".*

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[2] Preston-Shoot, M. (2018), "Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change", *The Journal of Adult Protection*, Vol. 20 No. 2, pp. 78-92.

[3] Responding to Self-neglect in Shropshire

5.4 The guidance then goes on to state: *"Consideration and application of the Mental Capacity Act (MCA) 2005 and associated Code of Practice should be prominent (and clearly recorded) in the assessment, management and intervention of all cases where self-neglect is identified. This should include where an assumption of capacity has taken place. The workers belief that the adult has capacity to make a specific decision should be recorded".*

5.5 The Mental Capacity Act Code of Practice (2005)[4] defines a two-stage test of capacity (please also see 5.7 below for clarification about this):

1. The diagnostic test – does the person have an impairment of the mind or brain, or is there some other sort of disturbance affecting the way their mind works?

2. The functional test – if so, does the impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Assessing if a person can make the decision in question is determined by a four-stage test referred to by Bennett (2010) as Understand, Weigh, Retain and Communicate.

1. Does the person have a general understanding of what decision they need to make and why they need to make it?

2. Does the person have a general understanding of the likely consequences of making or not making the decision?

3. Is the person able to understand, retain, use and weigh up the information relevant to the decision?

4. Can the person communicate their decision?

5.6 Whilst the Code of Practice states that practitioners should assume that an individual has capacity unless it is proven otherwise it can be argued that in Lily's case there was information held by agencies that would suggest that she had an impairment of the mind or brain. This impairment could have affected her ability to make decisions during periods of crisis.

5.7 Subsequent to the Codes guidance on assessing capacity case law (Supreme Court in A Local Authority v JB) has now determined that the current Code of Practice is incorrect. The accepted guidance now is that the following elements should be considered in the following order when assessing capacity:[5]

(1) Is the person able to make a decision? If they cannot:
(2) Is there an impairment or disturbance in the functioning of the person's mind or brain? If so:
(3) Is the person's inability to make the decision because of the identified impairment or disturbance?

Consequentially the new draft code to the Mental Capacity Act now includes the 3 elements above in sections 4.12 and 4.13[6]

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[4] Mantell, A & Scragg, T (2011), *Safeguarding Adults in Social Work*. SAGE Publications. London
[5] CARRYING OUT AND RECORDING CAPACITY ASSESSMENTS January 2022. *Mental-Capacity-Guidance-Note-Capacity-Assessment-January-2022.pdf (39essex.com)
[6] Draft MCA Code of Practice: summary - GOV.UK (www.gov.uk)

Working with people who self-neglect

5.8 Braye et al's (2014)[7] research found that at the heart of good practice when working with people who self-neglect there is "*a complex interaction between knowing, being and doing:*

- ***Knowing**, in the sense of understanding the person, their history and the significance of their self-neglect, along with all the knowledge that underpins professional practice*
- ***Being,** in the sense of showing personal and professional qualities of respect, empathy, honesty, reliability, care, being present, staying alongside and keeping company*
- ***Doing**, in the sense of balancing hands-off and hands-on approaches, seeking the tiny opportunities for agreement, doing things that will make a small difference while negotiating for the bigger things and deciding with others when the risks mean that some intervention must take place.*

5.9 The risks to adults with care and support needs through agencies not working together effectively can have a significant impact on outcomes for the individual. In his Learning from Safeguarding Adult Reviews, Michael Preston Shoot (2018) states *"A clear message emerges of the importance of multi-agency meetings, to support reflection and shared decision making. Multi-agency meetings are highlighted as particularly beneficial when a case has yet to reach the safeguarding threshold but where there are concerns about how agencies are working together to understand and manage risks".*

5.10 The Responding to Self-Neglect in Shropshire: Practice Guidance and Local Procedure makes it clear that cases should not be closed simply because agencies have not found a way to engage with them. Lily was closed to Midland Partnership NHS Foundation Trust and Shropshire Council due to "non-engagement". She was reopened to the Mental Health Social Work Team when there was a need for an assertive outreach approach which was required to prevent her from losing her tenancy.

5.11 On non-engagement, *a key message is to express concerned curiosity about possible explanations. Simply sending letters, expecting individuals to respond positively to clinic/office appointments, and closing the case when no response has been received is insufficient. Using different strategies to engage following missed appointments and monitoring cases through documented multi-agency meetings or "at risk pathways" are advised (Preston-Shoot:2018).*

[7] www.scie.org.uk/files/self-neglect/policy-practice/self-neglect_general_briefing.pdf

6. ANALYSIS

6.1 The analysis section of this report is going to explore the review's terms of reference in turn. It will look at the evidence presented to the panel and look to highlight any good practice as well as any learning.

There is evidence that Lily experienced mental health problems and that this could have contributed to self-neglecting behaviour. What evidence is there in this case that Lily's mental health was understood by the agencies involved? If it was not understood did this have a bearing on how she was supported?

6.2 There were a number of agencies that identified Lily experienced mental health problems in their agency information however as a collective multi-agency group, there was arguably a significant gap in the understanding of Lily's needs and how her mental health would impact her behaviour.

6.3 Lily had been diagnosed with both Schizophrenia and Depression and both disorders would have impacted upon how Lily would interact with others, how she engaged with services and how she behaved. In Individual Management Reports there is acknowledgment that Lily was discharged from services however it is noted that this is because of her lack of engagement or withdrawal from services rather than agencies being able to find a way to engage her.

6.4 There was no formal assessment of Lily's mental health during the period under review as services were unable to find a way in which to positively engage with Lily. The Mental Health Social Work Team's Individual Management Report noted that "*all visiting professionals seem to be of the same opinion re: low mood, withdrawal and non-engagement. What is not evident is thresholds regarding the nature and degree of the mental health state/disorder*".

6.5 Lily's GP notes that diagnosis of this patient was unclear. Lily had a diagnosis of Schizophrenia, for which she had been treated since being a young adult. However, her GP felt that Lily had more "*Paranoia and schizoid like personality. It maybe that there was even a personality disorder*". Adult Social Care, the GP and the Police all felt that Lily also had some form of learning disability, but this was not diagnosed.

6.6 Not having the correct diagnosis for Lily would have a significant impact on professionals' ability to understand her and her needs. This in turn would have a bearing on the support that she would receive.

6.7 It has been noted in other cases under review that there has been confusion about what an individual's mental health diagnosis. Where there are differences of opinion about a person's diagnoses, or presentations have changed over time or are no longer consistent with earlier assessments professionals should seek to clarify this through ensuring appropriate reassessments have taken place and are clearly recorded. **(recommendation 1)**.

What evidence is there that staff involved in this case had knowledge of and applied the Shropshire Safeguarding Community Partnership's Responding to Self-Neglect in Shropshire Practice Guidance and Working with Risk Guidance in their work with Lily?

6.8 The Individual Management Reports received from the agencies involved in supporting Lily clearly indicate that there was either no knowledge of these documents or if they were known about, they were not fully applied.

6.9 Two agencies responded that this question was not applicable to them. Both the Responding to Self-Neglect in Shropshire Practice Guidance and the Working with Risk Guidance are applicable to all practitioners who work with individuals who live in Shropshire. There is an expectation that agencies ensure that practitioners have knowledge of the key concepts within these guidance documents and are able to apply them in their work with people who self-neglect.

6.10 Other agencies were able to indicate how their organisation promotes this guidance amongst their practitioners. They then identified that the practitioners who came into contact with Lily during the scoping period of this review had not applied it sufficiently.

6.11 A recent survey carried out by the Self-Neglect Strategic Priority Group, asked its members to rate how confident they were that practitioners and managers in their area understand the key parts of the Self-Neglect Practice Guidance. The average score was 3.5 out of 5 (5 being very confident). When asked about their confidence in relation to applying the Guidance, the score went up to 3.6.

6.12 This survey was carried out with members of the Self-Neglect Priority Group, who are not front-line practitioners, and used a small sample. It is therefore reasonable to conclude that knowledge of and application of this guidance needs to be improved.

6.13 There is currently a task and finish group working on revisions to the Self-Neglect in Shropshire Practice Guidance. The aim is to ensure that there are more practical tools included to support practitioners in their work with individuals who self-neglect. Whilst this work is being done, I would recommend that agencies assure themselves that practitioners are using the current guidance when working with people who self-neglect to support their decision making **(recommendation 2).**

What evidence is there (if any) that the Police have received the necessary training on adult safeguarding, including how and when to raise an adult safeguarding concern in accordance with the Care Act (2014)?

6.14 West Mercia Police's Individual Management Report indicates that student officers join the force through the Degree Apprenticeship Programme or Degree Holders Programme. These programmes are managed in partnership with Staffordshire University and regional police forces. "Vulnerability" is a topic that is covered at various stages throughout the curriculum, topics include; identifying vulnerability, mental health, domestic abuse and sexual offences. The Care Act (2014) is covered, explaining how all first responders should make appropriate referrals, record and share information and take appropriate action.

6.15 Police practitioners follow the West Midlands Adults Safeguarding Policy and Procedures as well as the force policy and procedure for "vulnerability, information sharing protocols and individual practice guidance. These are available via the staff intranet page along with a tool kit. Force messages are also consistently issued regarding the role they play in protecting the most vulnerable members of our communities and that safeguarding is everyone's responsibility.

6.16 The Care Act 2014 determined that the term “vulnerable adult” was problematic, and the preferred terminology was “adult at risk” or “adult with care and support needs.” It is therefore advisable that the Police review their training to ensure that it robustly follows the accepted concepts when providing adult safeguarding training to officers **(recommendation 3)**.

Did the Police share concerns about Lily’s vulnerability to other agencies in a timely manner?

6.17 The Police were called by Lily’s neighbour several times when she was struggling with her mental health. This often occurs because members of the public do not know who else to call in these situations. There are clear occasions when the officers who attended Lily’s property liaised well with other agencies, contacting Severnside Housing to complete a joint visit, calling the Crisis Team for Lily and to advise them of the situation that was occurring and discussing their concerns with the ambulance crew whilst at Lily’s property.

6.18 The Police attended Lily’s property on 6 occasions. On 4 of those, they raised ‘Adult Protection Incidents’, on their return to the station, to be reviewed by the Harm Assessment Unit. Only one of these incidents was deemed by the Unit to require onward referral. The rationale given for the decision not to refer the others included “*No suggestion or indication she (Lily) is mentally unwell*”.

6.19 There were occasions that the Harm Assessment Unit did not make onward referrals because they felt the most appropriate agency was in attendance. However, on no occasion were Mental Health Social Work or Adult Safeguarding Teams in attendance at the address. Referrals for care and support and safeguarding are made to the Local Authority. The Care Act (2014) identifies the responsibilities of all agencies in terms of safeguarding adults with care and support needs. If it was deemed that Lily had care and support needs then onward referrals should have been made by the Police regardless of the other agencies that were present at the property as they had identified a need and had a responsibility to pass this on. There is evidence that when Lily brought a very long letter to the Police Station describing her concerns about issues, she found distressing an officer made considerable attempts to discuss this with her (4.16 and 4.17). However there does not appear to have been any consideration with health and social care colleagues the best way how to explore this with Lily using a multi-agency approach.

6.20 The Harm Assessment Unit use an Adult Risk Assessment tool which supports their decision making.

High Risk	**Abuse has taken place or is immediately imminent.** This is likely to meet the s42 Care Act standard made by the Local Authority Social Care. A safeguarding concern referral is required.
Medium risk	**Adults with care and support needs** An assessment of needs referral is required, so that the Local Authority can assess whether care and support of the person is appropriate, or other locally available support service is relevant
Standard risk	**No ongoing support needs identified** There is no continuing cause for concern. The actions taken at the point of reporting have effectively resolved the situation for the person and there is no identified need for further provision from services.

6.21 A soon to be published Shropshire Domestic Homicide Review saw several incidents involving an adult whereby the Police Officer involved completed an “Adult Protection Incident”, however the Harm Assessment Unit was inconsistent in its decision making for forwarding referrals.

6.22 Another Safeguarding Adult Review, which is still in its preliminary stages, saw two medium risk situations not referred further and one low risk that did receive an onward referral.

6.23 The inconsistencies into when to share information with other agencies can lead to delays for adults like Lily, who have care and support needs in receiving appropriate assessments and support. Although it is unlikely, given the information provided that Lily would have agreed to an assessment under section 9 of the Care Act (2014), a section 11 assessment of the same Act could have been undertaken. This is a statutory duty when a person refuses an assessment and:

1. The person lacks capacity or,
2. The person is at risk of abuse or neglect. This would include self-neglect.

6.24 It is however pertinent here to point out that it is not only the police’s responsibility to make onward referrals regarding concerns. All of the agencies that had involvement with Lily throughout the scoping period had opportunities to recognise her care and support needs and self-neglect risks and coordinate discussions about how to engage Lily.

The Scoping Panel were informed that a review of the Harm Assessment Unit was to be undertaken which would help address issues raised within this review. Can Police colleagues provide assurances about this work and how it will be reported to Shropshire Safeguarding Community Partnership?

6.25 West Mercia Police’s Individual Management Report stated that as part of its review of the scoping period, staff within the Harm Assessment Unit were contacted. It was identified that there was disparity in the level of detail provided by frontline officers when recording “Adult Protection Investigations” and completing risk assessments. It was felt that officers do not get specific training on what needs to be included to ensure necessary referrals are made and that they do not always understand the pathway which leads to referrals being made to other agencies.

6.26 Training is being provided for both staff in the Harm Assessment Unit and frontline officers regarding safeguarding and referral information. This will include the information needed in incident reports and risk assessments and how safeguarding information is reviewed and assessed when it has been received by the Harm Assessment Unit.

6.27 An organisational review is being undertaken of the Harm Assessment Unit’s operational practices in order to improve consistency in joint working practices. New standard operating procedures are being devised and the progress of these should be reported to the Joint case Review Group on a quarterly basis until they have been finalised **(recommendation 4).** A training package is being designed which will be delivered in 2023 to staff in the Unit and to frontline staff to support their understanding of this new operating procedure.

On 14.10.19, what evidence is there to support agency decisions to leave Lily at home without a formal assessment of her mental health or mental capacity? If her capacity was assessed, given that it is time and decision specific, what was assessed and how was this recorded?

6.28 On the 14th October 2019 Lily's property was visited twice due to calls to the police from her neighbour reporting that she was having a mental health crisis. The first visit was by Police and Severnside Housing who contacted the Ambulance Service as they felt that Lily was unwell and unsafe. It is documented that Lily refused all assessments and would not let the ambulance crew approach, she displayed aggressive behaviour during this time. West Midlands Ambulance Service note that "*on scene conversations took place between police, Severnside and Lily and she did have capacity*".

6.29 The second visit that day was when two members of the Crisis Team went to Lily's property as they had been unable to contact her on the phone following the earlier episode. They were joined at the property by an ambulance crew. Lily would not allow them into the property, and she was observed through the window to be "hitting herself and throwing objects".

6.30 At 17.38 West Midlands Ambulance Service called for police assistance and informed the call taker that the "*Crisis Team believe the female [Lily] will need to be sectioned based on what they have seen so far*". It is further recorded that the "*Crisis Team are not happy to enter without the police and said they will withdraw if police aren't able to attend shortly*". The log was reviewed at 17.51 and crew were advised that "*they must try and attempt in the first instance and then if any threats to make contact with police*".

6.31 Records indicate that Lily went upstairs in her property and was quiet. When police had not arrived after 30 minutes the Crisis Team and ambulance crew left Lily's property. No assessment of her mental health or mental capacity was carried out as no entry to the home could be gained.

6.32 West Midlands Ambulance Service have stated that their clinicians align with the principles of the Mental Capacity Act (2015), specifically in regard to the presumption of capacity. They do however recognise that such presumption does not negate the appropriate assessment.

6.33 During the first visit, the police indicate in their records that in terms of capacity assessment this was undertaken by the ambulance crew who were best placed to carry this out. When they were advised that the best course of action was to leave by the Crisis Team then they felt they had no grounds to remain at the property.

6.34 Severnside Housing staff were aware that Lily had mental health conditions however it is not clear from the records if this was shared with the ambulance crew on site to support their decision-making regarding capacity.

6.35 It is difficult to ascertain how Lily's capacity was assessed on this occasion. Capacity is time and decision specific. There is no record from any agency as to what decision it was that Lily had capacity to make. The diagnostic test of capacity relates to an individual having an "impairment of the mind or brain", Lily had mental health conditions which agencies were aware of that potentially would fall into this category, especially during times of crisis when her mental health had deteriorated. Lily was said to be aggressive and combative with erratic behaviour. Therefore, a more thorough assessment of her capacity was indicated. Especially given that staff from Midlands

Partnership NHS Foundation Trust had cause to consider an assessment under the Mental Health Act was potentially needed (6.32). West Midlands Ambulance Service determined that Lily did have mental capacity as part of their assessment on the 14. 10.17 (see 4.8) therefore an audit should be conducted by West Midlands Ambulance Service to ensure that they are assured that when staff assess capacity the specific decision and key elements of the assessment are satisfactorily completed. **(recommendation 5).**

6.36 Midland Partnership Foundation NHS Trust's records show that no assessment of Lily's mental health or mental capacity was undertaken on the 14.10.19. They state that this was because they had no legal powers of entry to the property. However, if they felt that a Mental Health Act assessment is required then under section 135 the Act allows for a warrant to be sought by an Approved Mental Health Professional from a Justice of the Peace for a Police officer to enter someone's home to ensure a proper assessment takes place. There is no evidence that the Trust had further discussions either within their team or with Shropshire Council mental health social work colleagues to determine if this cause of action was needed. All agencies should take steps to ensure that staff are aware of key elements of the statutory legal framework under the Mental Health Act. This includes a knowledge of when compulsory powers under the act may need to be utilised. This is to ensure that agencies understand when partner organisations need to be alerted so as to be able to consider their legal duties. **(recommendation 6)**.

When the Social worker was on annual leave on the 14.10.19 why was there no one available from Adult Social Care to advise when the Ambulance service telephoned the team?

6.37 Adult Social Care records indicate that when the Ambulance Service called on the 14.10.19 they went through First Point of Contact. Lily's allocated Social Worker was on annual leave and phone lines for the duty Mental Health Social Worker were busy. However, there were numerous calls between the duty Social Worker, Severnside Housing and Midland Partnership NHS Foundation Trust on that day as well as attempts made by the duty worker to contact Lily.

6.38 In the event of a Social Worker being away from the office, whether this be on annual leave, sickness or training then there is a duty system in place to ensure that crisis situations can be responded to. In this situation the duty worker was on the phone dealing with another matter at the time the call came in from the Ambulance Service. Once this had been managed the worker was able to respond and began to liaise with the other professionals who were involved.

Agency reports submitted note that Lily refused or disengaged from services. There are also frequent references to Lily being informed to seek help if she required it (some of these at times of crisis). Was it ever considered that agencies were overly dependent on Lily doing this and what were the contingencies if she didn't?

6.39 On 31.10.19 when Lily attended the Police Station in a distressed state asking to report mental and physical abuse by family members, an appointment was made for her to return when an officer was available as she was unwilling to speak to the front counter staff. When the police officer went out to see Lily, she would not let them in. When the officer could not find a way to engage Lily and get her to explain why she had attended

the station they left (as they had no power of entry) however they recorded an Adult Protection Incident and completed and Adult Risk Assessment.

6.40 These assessments indicated they had concerns for Lily's mental health as she seemed confused, had obvious mental health and learning difficulties and observations through the window of the property led them to believe she may need help looking after herself. The Harm Assessment Unit subsequently shared this information with Shropshire Council's Adult Safeguarding Team and Midland Partnership NHS Foundation Trust. This was expected practice by the officer who clearly identified Lily's needs and followed this up appropriately.

6.41 Midland Partnership NHS Foundation Trust opened a referral for Lily. They confirmed that she was still open to the Shropshire Council Mental Health Social Work Team and then sent Lily a letter. The letter requested that Lily contact the Access Team to discuss the referral and if she did not respond within seven days the referral would close. It also gave advice on referral after this date. A second letter was then sent to Lily from the Psychosis Pathway Team offering her an assessment appointment on 6.12.19.

6.42 There was liaison between Midlands Partnership NHS Foundation Trust and Shropshire's Mental Health Social Work Team. This liaison related to giving background information and any updates. Other than two letters being sent to Lily there is no evidence of any attempts to engage with her during this period. Lily did not contact the Access Team or attend the appointment she had been offered on the 6.12.19. As a result, both teams closed Lily to their service. There are recommendations in other Safeguarding Adult Reviews in Shropshire which ask agencies to ensure that practitioners have an understanding of and are implementing the Self-neglect Guidance. This is in particular relation to the closure of individuals to services when they have struggled to find a way to engage with them successfully. As there is action in support of this, I therefore will not make a similar recommendation here.

6.43 Lily's GP had not seen her for two years however the surgery had been notified of the activities of other agencies. The last prescription issued to Lily had been in May 2021, for Venlafaxine, an anti-depressant medication. Lily had also written to her GP during this period, some of these letter's contained accusations of previous abuse. In October 2020, the GP was contacted by someone from the Department of Work and Pensions as they had received a letter from Lily which contained accusations of childhood abuse and murder. The GP assured them that this was not untypical patterns of behaviour for Lily and that she and those around her were safe and well. The surgery did not share this with either the Mental health Social Work Team or Midlands Partnership NHS Foundation Trust. I recommend that the Integrated Care Board write to all GP Practices in Shropshire advising them that when material of this type is shared with the Practice that they consider it in the context of potential evidence of deteriorating mental health and consider the need for further assessment and/or referral to specialist services **(recommendation 7).**

Given Lily's preference for writing to agencies rather than speaking to them, how did agencies respond to the written communications they received from Lily (either directly or via other agencies) and how did they act upon any safeguarding concerns that were raised within them?

6.44 There is evidence that Lily did not communicate with professionals by telephone or face to face meetings but preferred to communicate by writing letters. These letters were her way of explaining how she felt and what was troubling her. The Mental Health Social Work Team, Department for Work, Police and Pensions and her GP were sent

letters. Records indicate that only one of these letters was shared with other professionals involved in providing support to Lily.

6.45 A letter that was written by Lily to The Mental Health Social Work Team was shared with safeguarding colleagues in a nearby County who could ensure that Lily's family member was safe from harm. Lily was informed that this information had passed on and efforts were being made to ensure the safety of members of her family. The letter was also shared with Midlands Partnership NHS Foundation Trust as they were working to support Lily at the time, and it was hoped that this would give them some insight into her state of mind.

6.46 Midlands Partnership NHS Foundation Trust uploaded the letter onto their system. At the time Lily was open to the Access Team but there is nothing recorded as to what action was taken as a result of the letter and she was closed to the service shortly after.

6.47 In the chronology from the GP there is evidence that they received several letters from Lily however there is not specific details about what each of them contained. There is reference to the GP reassuring someone from the Department of Work and Pension that the letter they received about childhood abuse and murder was a familiar theme in Lily's communication. It states that the GP has raised safeguarding referrals in the past relating to these. However according to the information available this was not done during this scoping period.

What evidence is there that when deciding to close Lily to services that there was a robust risk assessment in place? In addition, what had been done by agencies to promote and support engagement with Lily and the services that were on offer?

6.48 It is evident from the chronologies that agencies have supplied for this review that it was difficult for them to find ways to engage Lily productively in assessment and support for her mental health. There were times when she would seek help and then seemingly "push away" the services that she sought that help from. When working with people who have an inherent distrust of services due to past experiences this is a common feature.

6.49 However, in times of crisis it meant there would be a flooding of Lily's environment with people, this could have been overwhelming for Lily especially in the context of working in a trauma informed way. During these periods of crisis e.g. when workers were outside Lily's property trying to support her there would be two or more agencies working to try and resolve the presenting situation. There would then be a brief period of liaison between some of these agencies following the event however when Lily did not respond to offers of appointments she would be closed to services, with no risk assessment in place to try and prevent a reoccurrence. This is contrary to the Responding to Self-Neglect in Shropshire document referenced previously.

6.50 There is no evidence that a multi-disciplinary meeting was held with those agencies involved with supporting Lily to discuss the level of risk posed. This meeting could also have:

1. explored other effective ways of communicating with Lily which may have suited her and supported her to engage and help her to build a trusting relationship.
2. discussed the legal options available for intervention
3. ensured a robust multi-agency risk assessment was in place prior to closure of services and how to manage situations effectively moving forward

6.51 This is the fourth adult related statutory review in Shropshire since 2020 where the absence of having a multi-disciplinary meeting has been identified as a point of learning. All agencies should satisfy themselves that they convene multi-agency meeting when faced with individuals like Lily who have complex care and support needs that require a multi-agency response who they are struggling to engage with **(recommendation 8).**

6.52 What is pertinent to note, is that when a more assertive approach was taken by Severnside Housing due to the risk of Lily losing her tenancy, although at first reluctant, Lily did eventually leave the door open for Severnside's Compliance Officer and the electrician. She also engaged verbally with the Compliance Officer on some of their visits prior to her death. This Compliance Officer had been visiting Lily's property weekly for over 8 months (sometimes with a support worker from the Mental Health Social Work Team). This engagement appears to be an example of good practice as evidenced by the response to the visit noted at Paragraph 4.33.

6.53 It is recognised that services are juggling with budgetary and staffing issues across the system however there are individuals such as Lily where an assertive, yet person centred approach is essential. Longer term and patient engagement in order to build trust with individuals may well support to them to feel able to attend appointments for assessment of their mental health.

7. CONCLUSION

7.1 Agency interactions with Lily clearly did not result in her engaging with services to address the distress she manifested. On occasion she would demonstrate her agitation via her behaviours through shouting out and breaking her own belongings and home. There were also times when she would write to services. These often appeared to be incoherent and hard to understand. Despite this Lily was attempting to commence a dialogue. However, when services did attend her home, often when Lily was in a heightened sense of distress, she would refuse to discuss her difficulties and declined support. This then led to services being closed. It is understood that individuals need to be present for their mental health to be assessed. However, if the individual is in crisis at that time then it might be unrealistic to expect them to attend without having had time to form a relationship with the person doing the assessment.

7.2 There was a pattern of visits to Lily's home at times of heightened tension typically resulting in her refusing support despite the evident distress and history of mental health problems. It would appear that services did not attempt to convene a meeting to take stock and reflect upon this pattern. This could have involved consideration of trauma informed approaches to see if there were any additional impediments effecting Lily's ability to accept help. Such approaches often involve staff thinking of ways of encouraging the "opening doors" and creating opportunities for engagement.[8]

[8] Opening Doors: Trauma Informed Practice for the Workforce. Opening Doors: Trauma Informed Practice for the Workforce on Vimeo

8. RECOMMENDATIONS

8.1 **Recommendation 1** Where there are differences of opinion about a person's diagnoses, or presentations have changed over time or are no longer consistent with earlier assessments professionals should seek to clarify this through ensuring appropriate reassessments have taken place and are clearly recorded.

8.2 **Recommendation 2** Agencies need to assure themselves that practitioners are using the current Self-neglect guidance when working with people who self-neglect to support their decision making.

8.3 **Recommendation 3** The Police need to review their training to ensure that it robustly follows the accepted concepts when providing adult safeguarding training to officers. This is to include the preferred terminology in the Care Act 2014 of "adult at risk" or "adult with care and support needs".

8.4 **Recommendation 4** Until the organisational review of the Harm Assessment Unit has been completed and finalised there should be quarterly reports provided to the Joint Case Review Group as to the progress that is being made.

8.5 **Recommendation 5** An audit should be conducted by West Midlands Ambulance Service to ensure that they are assured that when staff assess capacity the specific decision and key elements of the assessment are satisfactorily completed.

8.6 **Recommendation 6** All agencies should take steps to ensure that staff are aware of key elements of the statutory legal framework under the Mental Health Act. This includes a knowledge of when compulsory powers under the act may need to be utilised. This is to ensure that agencies understand when partner organisations need to be alerted so as to be able to consider their legal duties.

8.7 **Recommendation 7** The Integrated Care Board should write to all GP Practices in Shropshire advising them that when letters are shared with the Practice, either from the patient themselves or by another agency, that they consider it in the context of potential evidence of deteriorating mental health and consider the need for further assessment and/or referral to specialist services.

8.8 **Recommendation 8** All agencies should satisfy themselves that they convene multi-agency meeting when faced with individuals like Lily who have complex care and support needs that require a multi-agency response who they are struggling to engage with.

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