Safeguarding Adults Review (SAR)

JA

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1. INTRODUCTION

1.1. JA was found deceased in her property after police gained entry following concerns that JA had not been seen for several weeks. JA lived with her son who was still resident at the property but had not reported her deceased. JA and her son lived in conditions of significant hoarding, self-neglect and had not engaged with services that were trying to offer care and support.

2. PROCESS AND SCOPE

2.1. The Terms of Reference, scope and methodology for the SAR can be found in Appendix 1.

2.2. The review set out to cover a one year prior to the death of JA. On accessing information available for that year, contact by agencies with JA was so limited that a decision was taken to use earlier periods of engagement to identify learning for moving forward with the systems and agency collaboration tools that are currently available to professionals.

3. THE REVIEWER

3.1. BDSAB commissioned an independent reviewer to chair and author this SAR. Karen Rees is an Independent Safeguarding Consultant with a nursing background. Karen worked in safeguarding roles in the NHS for a number of years. Karen is completely independent of BDSAB and its partner agencies.

4. FAMILY INVOLVEMNT IN THE REVIEW

4.1. Contact was made with JA's son to invite him to be involved in the review. JA's son agreed to be involved and telephone contact was made by the author as pandemic restrictions prevented face to face contact. JA's son's views are included throughout the report as appropriate to the learning.

5. JA RELEVANT HISTORY (Taken from an independent review conducted in 2015)

5.1. JA and her son (37 years) were long term residents of Barking and Dagenham in a flat owned by a private landlord above a shop in a small parade of shops.

5.2. JA was a woman of White British origin who attended university and is said to have studied Law, British Sign Language, and plumbing and gas as well as studying British Standards, at the same time as undertaking voluntary work at the Guildhall. She is said to have been a campaigner in the past and in later years acted as a moderator for several websites. JA was born in 1957 and died at age 62.

5.3. JA is said to have been a "hoarder" since her son was a child when she schooled him at home. The family participated in community activities during her son's childhood. JA's son told the author that his mother was his best friend who helped and supported him through his life. JA's son stated that the reason for the home schooling was that he was dyslexic and struggled to manage in mainstream school and with limited provision offered, JA made the decision to teach her son herself. JA's son said that due to his reading difficulties most of his learning was enhanced by engagement in various activities

including canoeing and rowing where he engaged with his peers.

5.4. JA referred to her father being a doctor and mentioned her mother, who is reported to have moved into a care home. It is reported that JA had a sister that she did not speak to. There are also references to friends who had been in touch with Adult Social Care.

5.5. JA was diagnosed with suspected Multiple Sclerosis in 1994 and references to having Chronic Fatigue Syndrome known as ME. When assessed at hospital in 2013 JA was said to be unable to mobilise since 2010. JA is reported to have a fractured foot in 2013. There are isolated instances where JA had been seen to walk with difficulty since then and had very limited mobility. JA was diagnosed with diabetes and given medication. JA was referred to as obese but may have lost some weight in more recent years. JA was anxious about her health and diet and had been assessed under the Mental Health Act on several occasions but not found to be suffering from a mental illness. JA became increasingly housebound and isolated. JA and her son appear to have been inter-dependent and concerned about each other but not always harmoniously.

5.6. JA and her son came to the attention of the Council in 2012 in relation to housing benefit issues. They had been removed from their home in 2013 and 2014 because the property was considered a public and environmental health hazard and potential fire risk to both JA, her son and their residential and commercial neighbours. On these occasions JA and her son were placed in different care homes, which they referred to as "prison", living in separate rooms independent of the wider care setting. On the first occasion they returned home after several months to the same conditions.

5.7. It was stated by professionals that JA preferred not to wear clothes. This was alarming for professionals. JA gave varying reasons for this. In 2013 she was in a care home following being moved to enable the flat to be cleaned. It is recorded in District Nursing records that, at that time JA did not have any under clothes or night clothes and just a few tops. Her son had arranged to meet the environmental health officer to gain access to more possessions from the flat, but this did not occur. In later times, JA complained that clothes touching her would cause pain.

5.8. Despite multiple efforts to engage and keep the family safe, the situation in 2016 and beyond did not improve. Both JA and her son were known to be intimidating to professionals, threatening complaints and litigation and would often film professionals that they came into contact with. Professionals reported manipulation of services and professionals by JA who would inform different professionals varying accounts of a same story.

6. JA KEY EVENTS/TIMELINE 2016-2020

6.1. The following represents a short summary of the key events, interventions and professional attempts to engage in each phase of the time period under review. This will inform the areas for in-depth exploration and analysis in section seven of this report.

6.2. It is important to note that by 2016 JA and her son were very well known to organisations and services as a family that were living in a high-risk situation, where mental capacity had been difficult to assess but where there was no reason to doubt capacity and where non-engagement, hostility and denial of

access had been a feature for four years.

Key Phase One - 2016

6.3. The beginning of this year saw another eviction of JA and her son following a court order to ensure the flat could be deep cleaned. This was the first intervention of a new social worker who had been allocated to the case. The family moved back to the premises following the clean.

6.4. JA was admitted to hospital from June – November due to kidney related issues. During this time, JA's son visited her on one occasion. A summary of hospital records at the time related to suggestions that, at times, JA could be a difficult to manage and demanding patient.

6.5. The social worker attempted to engage with JA's son every couple of weeks whilst JA was in hospital as there was a belief by professionals that it was JA who prevented any contact with professionals. JA had made it clear that her son was her carer, therefore the local authority was exercising their duty to support carers. This was unsuccessful; there was paper over the windows occluding visual contact, the letter box would not open, preventing calling cards and letters being left. On one occasion JA's son did come to the kitchen window but he was angry and would not engage. Therefore, in the time that JA was in hospital it was not possible to have an opportunity to talk to or offer a carers assessment to her son in any meaningful way.

6.6. JA was discharged from hospital with an indwelling urinary catheter. The district nursing service became involved when the catheter became blocked. It was again a feature that engagement was difficult. In summary JA would allow access to undertake elements of care that she needed e.g. to unblock the catheter, but any ongoing intervention was not possible as there was an ongoing refusal to let professionals into the property.

6.7. The GP also had some interventions in this period, mostly over the telephone when JA required specific treatment e.g. for pain. Communication between the GP and social worker was good at this time and referral for physiotherapy was made; there was no significant engagement by JA with the Physiotherapist.

6.8. It was also reported by the District Nurses that there was lifting equipment in the flat that was not in use; this had not been provided by any services that were involved. JA was sleeping on an air mattress on a hospital bed. JA stated that she needed a hard surface to sleep on. As this was not available the air mattress was removed by JA's son and replaced with a board that JA then slept on.

6.9. The district nursing service made a safeguarding referral at the end of the year.

Key Phase Two - 2017

6.10. At the beginning of this year, the safeguarding referral resulted in a multi-agency meeting. Due to the risks identified and the difficulties that professionals had in gaining access, JA and her son were discussed regularly in Integrated Care meetings. It is recorded that these were well attended by those involved and that there were clear minutes and plans produced. It continued to be agreed that both JA

and her son had mental capacity. Concerns were being raised as to how far services could go without breaching their human rights.

6.11. An example of issues in this period was the buying of furniture to furnish the flat post the deep clean. The family refused the furniture that was purchased on their behalf. Further residual issues related to a substantial amount of cash that had been removed during the deep clean. It had been sent for specialist cleaning; this was now in the bank account of the council. The council wanted to return it, but the family wanted it returned in cash; JA and her son did not have bank accounts. This situation was not resolved during the timeframe for this review. It is apparent that this issue is still outstanding with ways forward being identified.

6.12. At the beginning of 2017 the GP did see JA at home and was able to engage JA in a thorough examination. The GP planned to chase the urology department for a further appointment regarding JA's kidney problems, arrange blood tests and commence some new pain medication.

6.13. JA told the GP that her mistrust of adult social care was due to the removal of appliances from the property. There continued to be good communication between the GP and the district nurses with feedback to the Integrated Care Meetings. Ongoing GP involvement was limited to telephone consultations. The blood tests were attempted but the team that take bloods declined to visit further due to the conditions within the property.

6.14. JA did engage for a time with the multiple sclerosis nurse specialist; this was not sustained.

6.15. Safeguarding referrals relating to self-neglect were made periodically; the district nurses and GP made referrals in this period.

6.16. During this year JA called an ambulance herself and spent a few days in hospital due to a hip abscess.

6.17. In May, following an Integrated Care Meeting, a referral was made to the Mental Health NHS Trust's Acute Access and Brief Intervention Team. The purpose was to undertake Mental Capacity assessments on JA and her son and to try and encourage engagement with mental health services. This was not successful as there was no engagement from JA or her son; they were discharged from the service.

6.18. Later that year an independent care agency was approached by Adult Social Care to work with the family due to the mistrust of the local council. This was not successful as there was no engagement from JA or her son.

6.19. JA's son engaged the services of a local councillor who would regularly raise concerns with the local authority regarding the family's needs and concerns.

Key Phase Three - 2018

6.20. In the beginning of this phase there were some successful joint visits between the social worker and the district nurses. Some of the district nurses were able to start to build rapport with JA. These visits needed some persuasion; however, district nurses were able to treat the physical conditions such as

pressure ulcers. Once they had completed their care, they were required to leave by JA. During this time, the district nurses were relied on to feed back to the GP and social worker who were no longer able to get access.

6.21. A new social worker was now in role and requested a mental health assessment from the GP for JA. This did not take place as JA refused.

6.22. Compliance with district nurses was then minimal but JA was communicating with the multiple sclerosis nurse. All information was being fed into the Integrated Care Meetings, but no agency was able to make any progress in gaining meaningful engagement. Whether appointments were planned and booked or unannounced appeared to make no difference to whether access was permitted.

6.23. A further safeguarding referral was made by district nurses in March. The Community NHS Trust had recorded the family on the High-Level Risk Reporting process in order that senior managers were kept informed of issues.

6.24. At the end of March, the social worker presented the case to the Complex Case Panel. This resulted in a raft of actions to ensure that each agency and service was communicating and recording all attempts to engage and gain access, this included actions to ensure that legal services, housing and environmental services were aware of the information and level of risks.

6.25. As concerns regarding non-engagement were escalating there was a multi-agency meeting in April where a large number of services were represented. An update of history and current concerns were presented. The main outcome of this meeting was to arrange a visit to undertake a Mental Health Act assessment. When the GP and Doctor attended, access was refused by JA. The Approved Mental Health Professional immediately applied to the court for a warrant under for a s135 of the Mental Health Act[1] to remove JA to a place of safety for assessment. The request was declined by the court as JA had capacity to refuse, and no evidence of a mental health disorder had been presented.

6.26. A further professionals meeting was convened for later in April. At this meeting a District Nurse who had gained access and spoke to JA informed the meeting that there appeared to be no current medical issues. JA was in a broken bed in the kitchen. The state of the bed was cluttered but the kitchen was not too bad and there was no smell. The other rooms were thought to be very cluttered, but access was never allowed into those rooms to any visiting professional for an assessment to be carried out. A letter was sent after the visit to JA to ask her to make contact with a time and date for the bed to be replaced however she did not make any contact.

[1] **Section 135 (1) of the Mental Health Act** is the power to remove a person from a dwelling if it is considered they have a mental disorder and that they may be in need of care and attention for this. With the agreement of the person they can be assessed at the dwelling or removed to the place of safety for the assessment to take place there. The process is for the Approved Mental Health Professional to present evidence at a Magistrates Court in order to obtain a warrant which will authorise the Police, an Approved Mental Health Professional and a registered medical practitioner to gain entry to the premises in order for assessment to take place there or for the person to be removed to a place of safety. Once granted the Approved Mental Health Professional with the Police and a registered doctor can enter the property and formulate their assessment or remove to the place of safety if required.

6.27. The meeting concluded that as there were no medical issues and mental health and mental capacity issues had largely been ruled out (historically) as of concern the current risks were mainly environmental. It was reported to the meeting that the landlord had done everything possible within the law and duty to take action but had not been successful. Offers to rehouse the family to a more suitable environment where caring would be easier had been refused by them. Meetings between the local councillor, head of service for the council adult social care and JA's son were mainly regarding the money that had been removed and the whereabouts of the washing machine and cooker that had also been removed. There was no resolution to either of these issues.

6.28. A further Complex Case Panel meeting was held in June where it was largely concluded that professionals would continue trying to gain access and that a solicitor would be engaged to return the money to the family. Plans were also to be put in place with the ambulance service in case there was ever a need to remove either JA or her son from the property in an emergency.

6.29. In November, a new social worker was allocated who sent contact details should JA need any support. The SW also contacted the GP for an update; this was declined due to confidentiality. At the same time the council environmental enforcement team contacted the Social Worker as there was a warrant to clear the property and temporary accommodation was needed for JA and her son. A date was never confirmed for this.

6.30. In December the Social worker requested that a joint visit was undertaken with the fire service for safety checks; this was arranged for February.

Key Phase four - 2019

6.31. In February there was a service restructure within the district nursing service. When caseloads were reviewed within the restructured service, JA was discharged as there was no recent activity or care being actively delivered. The Social worker and GP were made aware.

6.32. It is of note that there was no contact from JA to the GP in 2019. Throughout 2019 there is evidence that the diabetes eye screening service were attempting to receive confirmation from the GP that JA should be withdrawn from the diabetic eye screening service due to an inability to attend the screening appointments.

6.33. The joint visit with the fire service did not take place as the fire service did not arrive at the appointed time. No further action was taken.

6.34. In October the social worker wrote to JA offering further contact and support. There was no response.

6.35. In November a rearranged joint visit with the fire service was attempted with no response. A phone message was left by the social worker to make new arrangements for a visit; the fire service also attempted contact with no response to either attempts.

6.36. A further joint visit was undertaken in January with no success. Neighbours stated they had not seen JA's son and a friend was contacted who also stated that there had been no contact over Christmas.

Police gained entry when JA's son answered the door to them. JA was found deceased in bed. JA's son stated that JA had died in October.

7. AREAS FOR LEARNING AND IMPROVEMENT

7.1. The analysis section takes a strengths-based approach identifying what went well and then building a picture of areas where learning has occurred. Systems and services that worked with JA have been updated and improved since this case. This is due to natural ongoing improvement, service changes, and elements that have been changed already due to early learning from this case.

7.2. What has become clear to the author in undertaking this review is that it is likely that JA and her son's mistrust of services was established several years before this review was commissioned. The review heard that there was anecdotal evidence of difficulties in a previous area, but there was no handover of any information or direct evidence of when and how or why difficulties started. The author would consider that it was highly unlikely that JA would change that viewpoint. The purpose of this analysis is to identify anything that may have made a difference earlier and that should be applied in the future when working with complex cases of this nature.

Understanding History, understanding the person

7.3. It was clear from the discussions and information received that some of the history of JA and her son was understood and recorded in assessments. A single agency review commissioned by the Local Authority Adult Social Care in 2015 also included some of this.

7.4. Professionals attending the workshops reflected on the importance of understanding a person's history in order to inform current practice of the life experiences that may be having any impact in a person's adult life, particularly any trauma.

7.5. Albeit that there was some history known, there was no indication as to any triggers for hoarding behaviour, nor why JA was so unwelcoming of support. Professionals continually mentioned JA choosing to home school her son. This appeared to be well known; the reason for this choice was not clear but seemed to be mentioned by many professionals that the author spoke to. It could be suggested that this appeared to therefore be significant to professionals but with no evidence as to why that was. Many children are successfully home schooled with parents choosing to do this for many reasons. If this was being viewed with concern, then question and interest in this decision to the family may have provided some answers and settled the concerns or it may have indeed raised a concern or at least given the understanding of a longer-term mistrust of statutory services.

7.6. When the author spoke to JA's son, he identified the reasons for the decision to home school and that his mother took him to various activities and outings to enhance his social interactions and increase his experiences as part of his education.

7.7. There was little understanding of the father of JA's son, the decision to home school and whether the family had come to the attention of services when JA's son was a child or adolescent. There had also been questions raised about the family relationship, whether there was any control in the relationship

or any details of why there were reports of the family preferring not to wear clothes at home. In later years the district nurses commented that they never saw JA's son without clothes and that JA told them that clothes cause her pain and that she did not like clothes touching her.

7.8. It does not appear that there is any record of if this was something that the family had always done e.g., as within a naturist culture. It does seem that there was a view that the unconventional life that was led by this family was of concern; no professionals appeared to be able to say whether there was any direct evidence of concerns of a safeguarding nature related to the relationship.

7.9. The author accepts that it would have been very difficult to identify any relevant history latterly but could have formed a larger part of the initial contacts. At this point, if information had been refused then documenting of that would have been helpful to later practitioners.

7.10. It can be suggested that, at the point of professional contact, one may never know when information may become of use in the future.

7.11. Barriers to understanding history can be loss of information when new systems come into use, workers change, and older records may be archived. It is possible to gather information from other professionals. This often involves current issues; however, history of relevance could also be requested from e.g., GPs. Other barriers in this case in the timeframe reviewed appeared to be that professionals were fearful of asking questions that may have attracted an angry response and impertinence in JA; professionals were usually very careful what was said so that they were not asked to leave.

7.12. There does appear to have been some reluctance to apply professional curiosity because of the fear of rebuff. An example of this was that JA had her bed in the kitchen. Professionals did not understand why this was but had assumed that his was because there was a likelihood that other rooms were too cluttered for the bed to be in. When asked by the author, JA's son stated that this was because there were no curtain rails in the rooms. The rooms on the front of the property were on a main road and so offered no privacy. The kitchen was at the back and was therefore afforded more privacy. This also explains why there was paper stuck up at the windows as it was a simpler way to provide coverings to the windows.

7.13. Professional curiosity appeared to have been paralysed by fear of getting on the wrong side of JA.

Learning Points:

- Gathering and understanding history in early engagements with people can enhance understanding of the person.
- Understanding the person can increase an understanding of issues that a person is facing and lead to informed assessments**.**
- Professional opinions should be backed by evidence or clearly recorded that it is professional's opinion/view.
- Application of professional curiosity, in a professional enquiring manner may elicit information regarding apparent lifestyle decisions.

Building, sustaining and managing relationships

7.14. What is really clear from history gathered, documents reviewed, and professionals spoken to, was the huge efforts that were put in to try and not only engage with JA and her son but also to try and improve their living circumstances. Many attempts were made to engage and build relationships. Some professionals succeeded for a while but then things would break down. Meetings that were taking place discussed which professionals were better placed to be accepted by JA and that those who did gain access would feedback to those that were being denied access. None of this was successful or sustained. In 2019 professionals had more or less retreated from the family but left the door open with contact details and occasional letters and phone calls letting JA know that contact with services could still be made and services offered.

7.15. It is also very clear that the relationships between social workers and JA broke down many years prior to the period under review. Indeed, it was very likely that there was never going to be a point where JA would agree to having social care support and that this would always be a negative area. Relationships with health professionals on occasions was slightly better.

7.16. Having spoken with JA's son, the author ascertained that there were two main areas of contention. Following the deep cleans JA wanted back her appliances that had been removed (washing machine and cooker). She felt that the action to remove them was unnecessary. JA's son told the author that 'the straw that broke the camel's back' was following a call from a district nurse that JA later, after a follow up on the call, found out that it appeared to have been made by a social worker. JA complained but was told that there was no evidence of this. JA felt that this had been a trick to try and gain access and engagement and she was very angry. JA's son did not know when this was, but he stated that, in his eyes, there was definitely no going back after this.

7.17. Practitioners in the workshops reflected that over time, the knowledge of the demeanour of JA, her ability to intimidate professionals and play them off against each other was well known. There was a comment that this was even known by those that were in the same teams but had never met JA.

7.18. This appeared to lead to JA steering what contact she wanted with professionals and how she wanted communication and relationships to be, rather than from a place of mutual respect and negotiation.

7.19. Some workers were certainly fearful, and one worker described how knowledge that the case had been allocated to them caused a great deal of distress. A difficult piece of work had been allocated. The worker had learned from colleagues that they would need to be very careful what they said, as everything would be turned around. The worker was told of the anger of JA and that these were very clever people. Complaints, large amounts of emails and other abusive communications were often a feature in disputes about care and support. This made the new worker very nervous, and this had an impact on their sleep at the time. Managers were reported as being supportive, but it was not clear to that worker whether they would be held to account in the case of any serious issues.

7.20. Contact that the family had with local councillors often resulted in 'orders' from those councillors for professionals to take action. Although this appeared to create an extra element of anxiety for frontline professionals, for managers in contact with those councillors, it was a line of communication that at

least provided some information that was not available directly i.e. that JA and her son were able to communicate their concerns.

7.21. It is easy to see why professionals were unable to build or sustain relationships. Building on the last section, on top of not knowing very much about triggers for these behaviours, any current circumstances that may have been creating additional difficulties e.g. pain and frustrations from lack of mobility were not understood because professionals did not have the relationship where they felt that they could find out more about why JA behaved in this way. No professional directly challenged her behaviour, partly due to fear and partly because they did not think that this was good practice. If the behaviour had been one of physical violence, then the reaction would have been very different.

7.22. There was no sense from anyone working with JA of what it was that JA wanted but a great deal of what she did not want. Fear and negativity in relationships between people and professionals can lead to a paralysis, preventing innovation and a willingness to try again.

7.23. In cases of this nature professionals need a lot of support, guidance and frameworks to work with. These can them be applied to give structure and process to those people that are difficult to engage and offer services to.

Learning Points:

- Understanding of the person and their history is key to building relationships
- Punitive and enforcement action without ability to negotiate is likely to lead to a breakdown in relationships
- Hearing the voice of the person regarding their needs and wants can be supportive to relationships.
- Passing historical information regarding relationships to new workers should remain factual and objective rather than based on assumptions and subjective views.

Frameworks for engagement- Self Neglect

7.24. As stated previously the way that JA and her son were living was observed as self-neglect with hoarding behaviour. Self-neglect is defined in the Care and Support Statutory Guidance[2] as:

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

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

[2] **Care Act Guidance: Care and Support Statutory Guidance** (2016) https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
Updated 2018 with no changes to Chapter 14 Safeguarding

engagement with health and/or social care staff and other services/agencies)

7.25. Various efforts had been made to give the family a blank sheet to start again. This had been undertaken by court orders to remove JA and her son and to undertake deep cleaning. When they returned the second time, their belongings had been moved, some had been stored and most of the rubbish had been removed. For those that hoard, the understanding of triggers to this is important and to many, the sudden removal of items that they have become attached to can be hugely distressing.

7.26. When services first became involved, organisations were beginning to recognise hoarding and self-neglect but there was very little research at the time. As the adult safeguarding agenda was increasing, there was a recognition that many cases of self-neglect were coming to the attention as safeguarding cases. More research was being undertaken and guidance was being published[3] [4]. Then, when the Care Act was enacted in April 2015, it was included amongst the additional categories of abuse.

7.27. It is known that the safeguarding route for self-neglect was not initially well understood, particularly where a person was assessed and/or assumed to have mental capacity to make decisions about their living arrangements.

7.28. Best practice in self neglect is now a much more phased and understanding approach in order to get to the root of the self-neglecting behaviours, assess the risk and plan for long term interventions that will support gradual behaviour change. There are still occasions where court action can be taken. As became clear in this case, much of the action that can be applied for via the court relates to those that do not have mental capacity and where the Mental Health Act cannot be applied. It is also possible to undertake action where there is a risk to others. In this case that risk was highlighted previously but not in later years.

7.29. The author would suggest that there is now a much better understanding of ways forward with self-neglect but that it is still one of the most difficult elements of health and social care practice to work with. It is a challenge against the way that a person may have lived for many years. Understanding mental capacity is at the heart of knowing how to manage self-neglect.

7.30. It is also key to be able to build relationships in order to work effectively with self-neglect. In this case the previous two sections have highlighted the situation with relationships and understanding history. With these having gone before, it was not possible to apply up to date research and good practice without being able to develop trust.

7.31. Effective multi agency working is also a positive way to work with self-neglect cases and this did happen in this case but there may have been more cohesion on this element by use of the safeguarding process (see later).

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

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

7.32. Moving forward with new and existing cases, use of the hoarding and self-neglect guidance and policy and process will help. The author suggests that local guidance would benefit from an update and refresh particularly to include examples of cases where practitioners have been able to support people to adopt some change in lifestyle choices.

Learning Points:

- Use of up-to-date guidance regarding self-neglect can be supportive to professionals
- Understanding the history of the person may evidence triggers for self-neglect and hoarding.
- Working with self-neglect can be challenging and support and guidance is required by line managers and other support networks.

Frameworks for engagement- Engagement with professionals, Joint Care Planning

7.33. Professionals tried various ways of making contact and followed up failed attempts to see JA. There is good evidence that no one gave up trying until the risks appeared to be less, even then, there was still communication to remind JA that a service was still available should the family require it.

7.34. When this was discussed with professionals in the workshops, it was reflected that the barriers to engagement, previously discussed, were those such as the broken relationships, workers paralysed for fear of getting it wrong from a service and person perspective and the general negativity that this was a difficult family to work with.

7.35. This reflection led to a consideration of person-centred care[5]. Person centred care and involvement of the person in their care is key to overcoming early barriers to engagement. It was agreed that this is known to be best practice but that services are sometimes not very good at it, particularly where it is difficult to engage with a person. It is not clear that JA was fully involved in planning her care, received copies of her care plans to agree and sign or that they were reviewed with her.

7.36. It is not possible to completely ensure person centred care if the service being requested cannot be commissioned or is not in the remit of that service. It was known that JA often requested services and equipment to be delivered in certain ways. Professionals reflected that, no matter what the difficulties are, the start of engagement with a person should provide clarity on the limits of the service, what it can provide and being clear about what it cannot provide.

7.37. When JA's son spoke to the author, he indicated that JA and himself as carer, were frustrated that a hoist could not be provided. The Occupational therapy assessment had indicated that any hoist would need to be fitted to the ceiling. The outcome of this was that the ceilings were not able to take the hoist

[5] The Health Foundation has identified a framework that comprises four principles of person-centred care:

- Affording people dignity, compassion and respect.
- Offering coordinated care, support or treatment.
- Offering personalised care, support or treatment.
- Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

https://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf

and that there was not enough space in the property for equipment to be safely used. JA's son stated that this meant that he could not care properly for his mother. The offer of a move to a new home that would have the space for care to be delivered and equipment installed was refused. JA's son indicated that as 'sitting tenants' they had security with their current tenancy. This could have indicated that they were fearful that other landlords may not have been so 'accepting' of their lifestyle and levels of hygiene.

7.38. In cases where there are difficulties, professionals could consider contracting with the person. Care planning will be discussed in the next section but at this point it is worth noting. This is something that is used more with those that have demonstrated violence and aggression towards workers, however it could be used for those that are not engaging. One professional felt that they had informally contracted with JA regarding the care she would receive but this was not formalised and there was no challenge back if JA then strayed from what had been agreed.

7.39. It is clear that there was good joint planning and multi-agency meetings through the integrated care process and the complex case panel process (discussed separately due to its significance). The barriers to this element were not only those discussed before but also some of the organisational change that was happening at the time.

7.40. Adult social care mental health teams and social work teams were previously working as one team. Those teams, as is the case nationally, divided into their separate organisations; teams became more distant to each other and were no longer co located. Records access also changed in that the records became separate. When situations like these occur, it is important that professionals continue to work and plan jointly; it is easy for professionals to consider the negative aspects of organisational change where they find it difficult and less easy to find solutions. Staff reflected on this and agreed that it can be difficult to find the positive and be solution focussed in finding new ways of working collaboratively and effectively.

7.41. Despite that, as stated there was good joint working, what did not appear to be prominent was extending the joint working to JA. As an independent reviewer it really did feel like the family and professionals were poles apart with no one appearing to be able to find a way forward to an agreement regarding what professionals felt the family needed and what the family wanted or did not want.

7.42. There is evidence that JA knew of some of the meetings that were happening and that she was informed of the outcomes and plans. There was no evidence that there was a proactive approach to including JA more meaningfully in meetings that were about her. Notwithstanding that by 2016 this had become very difficult; it does not appear that this had been evidenced consistently earlier in engagement.

7.43. It is known that those multi agency meetings that were happening did not require consent from JA due to the high-level risks, however more active attempts to inform her of all meetings, copy her into the minutes so that she was aware of what was discussed may have had a double benefit. JA would have been very clear on what the concerns were and how much services were trying to support her as well as what actions could and could not be taken. More importantly there may have been more positive use of language and discussions knowing that the minutes would be shared. JA could also have been

given invitations to meetings/parts of meetings with representation and/or advocacy.

7.44. It cannot be known if JA would have engaged, however it would have been evidence that there were attempts to resolve the polarity and it could also have given JA a more positive voice than the one that was heard by professionals.

Learning Points:

- When engagement has become difficult it is worth reviewing methods of contact to ensure all ideas have been considered
- Clarifying service limits can help be useful when a person is demanding delivery of services that are not possible
- Person centred care is important to evidence that it is the person's needs and not the service needs that takes precedent.
- Involvement of the person in meetings as well as planning for their care can evidence efforts to engage the person ensuring openness and transparency of care offered/delivered.

Frameworks for engagement- Safeguarding Planning

7.45. There is strong evidence that several professionals made safeguarding concerns known and referrals were made; safeguarding adults work was ongoing. It appears that because of the difficulties, that the safeguarding process did not have a beginning and progress through to resolution under S42 Care Act safeguarding arrangements. Meetings were not identified as part of the safeguarding process and there was no clarity of decision making leading to strategy and threshold discussions as part of an ongoing safeguarding process. There is evidence that contact was made with JA regarding some referrals that were being made as is required under the making safeguarding personal approach. The Making Safeguarding Personal (MSP) initiative began as far back as 2009 by the Local Government Association and Association of Directors of Adult Social Services[6] to ensure outcome focussed, person centred responses to adult safeguarding, rather than it being a process that happened to people without knowledge. This has since become enshrined in the Care Act (2014) and requires that the adult and /or their representative is part of the safeguarding process. Any conversation with JA regarding safeguarding indicated that she did not feel that she needed safeguarding and that she did not require care and support.

7.46. Professionals reflected that safeguarding appeared to be dipped in and out of with evidence of scattered referrals with evidence of conversations and meetings. Some multi agency meetings clearly had actions but it did not appear that any of these meetings were reconvened to review impact of actions. There is no evidence of a formal Section 42 enquiry progressing; the only record of S42 ended because JA did not want a safeguarding service. As JA was deemed to have capacity this would have been the right approach. There was, however, no other obvious plan that came as a result of a decision that S42 was not the appropriate way forward.

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

7.47. Professionals were again paralysed from following usual processes as they did not think that anything that was undertaken would make a difference. Albeit that the threshold for a s42 enquiry may not have been met, it would still have been important to record the reasons why and have an audit trail of the safeguarding process that was easy to identify. None of the plans in place were identified as safeguarding plans.

Learning Points:

- The safeguarding framework as outlined in the local safeguarding adults policy and procedures offers opportunities to have an umbrella framework for all safeguarding referrals, decision making, meetings, planning and review.
- Safeguarding episodes should be clearly visible in recording systems.

Frameworks for engagement- Complex Case Panel/Safeguarding Adults Complex Case Group

7.48. As a result of the complexities of this case, the Complex Case Panel was developed. JA was referred and discussed at the panel on two occasions, which is testament to the understanding that professionals had regarding the complexity and the difficulties that working with the family presented. The process is good evidence of strong practice to support discussion of complex cases.

7.49. On both occasions the issues were discussed in depth with the panel. At the time, the process was not well developed. Cases were presented in isolation, although minutes were taken, and actions set, there was no review of these. This meant that there was no review of whether actions had made a difference to whether the situation was escalating. If there were ongoing concerns, the case had to be referred back.

7.50. These issues have been recognised. As a result, a refreshed process has recently begun. The Complex Case Group is now a subgroup of the SAB and is retitled the 'Safeguarding Adults Complex Case Group' (SACCG). This will promote appropriate multi agency and independent oversight and governance. Feedback on themes and trends are presented to the SAB quarterly.

7.51. The process addresses the issues raised above and although it is early days, it has the potential to be beneficial in cases where professionals have become stuck and paralysed to innovation. Being supported in this way at a senior level is likely to be effective in enabling practitioners to feel that risk is being shared and that they are not holding it alone.

7.52. This review has considered some additional elements to the process that may help to bolster it further:

- Ensuring that the process guidance documents are available on the SAB website and has a Quality Assurance and Version control front sheet (or equivalent).
- Ensuring that there is clarity that attendance and presentation of a case can be by more than one agency, thereby multi agency approach is maintained within the meeting from those key frontline practitioners.
- Ensuring that minutes are filed within patient/client records across all involved agencies.

- Exploration of joint recording systems across agencies for complex cases.
- Clarity that there is addition to 'scope of cases' regarding those where an up-to-date assessment is not possible due to no access/no engagement (or adding that type of case to scope of cases).
- Adding 'stepping back of services' (see later) to scope of cases as a must when this is being considered for non-engagement.
- Consideration of legal representation either for all or 'as required' cases

7.53. The audit and reporting on the updated process will provide evidence of its efficacy in managing cases where a person engages reluctantly and where risk is high.

Learning Points:

- The Safeguarding Adults Complex Case Group process offers a team around the person approach.
- The approach should be open to all individuals who are frontline professionals in a case.
- Ongoing evaluation of new processes allows continuous improvement.

Legal Literacy and Support

7.54. It is known that legal advice was taken at various points throughout the time that services were involved with JA and her son. Consideration was given to the use of the Court of Protection and a s135 Mental Health Act application was made to the magistrate's court.

7.55. Neither of the above processes were able to be pursued. In the case of the Court of Protection, the powers of that court only extend to those people who do not have capacity to make their own decisions and that there is challenge to the decisions being made on behalf of a person that leaves them at risk. There was no evidence that JA lacked capacity that could have supported the use of the Court of Protection.

7.56. To enable the use of a s135 there would have to be a belief and assessment that a person was suffering from mental disorder. There was never any evidence of JA having a mental disorder.

7.57. Practitioners were not clear on how and when legal advice was sought and did not feel that legal involvement or advice had enabled them to be any clearer on what could legally be done to support them to support JA.

7.58. It is noted that legal advice is required to be sought through senior managers and it is usually senior managers that have the direct dialogue with legal advisors which might be why frontline practitioners do not always feel they understand what advice is given. It is also the case that legal advice is often sought on an ad hoc basis when issues are escalating, a particular action is being considered, or advice is related to a specific element of the case. In this case there was advice sought regarding the money removed during cleaning and options available for return as JA and her son wanted it back in cash format as that was how it had been removed.

7.59. Those working regularly with the legal services within the local authority report that the legal services department is good and that services feel well supported. Consideration could be given, through the SACCG, to having more ongoing legal advice so that those giving advice could be more appraised of all the issues in order to have a more holistic view of the case issues. In discussing this review with the local authority legal services, it was highlighted that it would be beneficial to involve legal services at a much earlier point in a case so that ongoing knowledge and advice can be given where needed as opposed to trying to resolve issues later that have become more and more complex. It was also discussed that although legal advice needs to be approved at head of service level, conversations are often held with the front-line practitioners, which has improved understanding of legislation that can be used and that cannot be used.

7.60. It is also important that it is not only the local authority legal advice that is sought but that individual advice is also sought where other agencies are having difficulties in engaging and delivering services. This would ensure that each agency has the support to understand what is and is not possible, based on the care and services that they deliver.

7.61. It is also clear that housing legislation was not used and fully understood in this case, mostly due to the property being a private tenancy. The Private landlord did engage at some level but not consistently. It was clear that JA wanted to stay in this property, despite that fact that an occupational therapist felt that the equipment that JA needed could not be safely installed. JA's son told the author that he considered that this advice was wrong and that they [services] should have provided whatever was needed within their current accommodation rather than having to move to receive these services.

7.62. The local authority housing department responsible for overseeing the Private Rented sector did not appear to be able to enforce actions that a private landlord can take, and it is not clear if the duties carried out by a private landlord were ever able to be undertaken but these were not challenged. For example, a landlord has a duty to ensure that the properties that they let have safety checks related to gas and electrical appliances. Local authority housing team did not appear to enforce the private landlord taking any action over the concerns of fire and safety risks at the property.

7.63. The above considerations lead to learning for moving forward with complex cases of non-engagement, self-neglect and hoarding where a person retains capacity and has no mental health disorder.

Learning Points:

- Where appropriate, when legal advice is considered to be necessary, all agencies should seek this from their own service delivery perspective.
- It is beneficial to have early and ongoing legal support to enhance full understanding of a case and that all aspects of legal possibilities are explored when dealing with cases of a complex nature e.g., those case that fit the criteria for the Safeguarding Adults Complex Case Group.

Stepping back services

7.64. The Diabetic eye screening service had been informed (it is not clear by whom) that it was not possible for JA to attend diabetic eye screening services. This service is essential to ensure that complications

that can occur from diabetes are noted early and are treated to prevent eventual blindness.

7.65. After several attempts to gain information from the GP, a letter was received confirming that eye screening services had been withdrawn. It is of note that this was recognised in the request from the author for information from the GP and the receipt of confirmation that this withdrawal of services was very rare.

7.66. It does not appear that any other service considered formally stepping back services. It is easy to see why this might be. Health and social care practitioners undertake their roles because they want to help and support people to live well and safely. When a person has health and or social care needs, professionals want to do all they can to support a person. The services that can be offered are not without limits and most services have thresholds for triggering the service. Some thresholds are set nationally, and some are set locally.

7.67. It often appeared that the services that JA and her son wanted could not always be provided in the way that they requested e.g., equipment provision. It is also of note that the services that professionals felt that the family needed were not in line with what they wanted. This was specifically the case in later years where trust and relationships had broken down.

7.68. JA was known to have mental capacity and did not have a mental disorder. JA stated at one point that she was fed up with the amount of people that were constantly contacting her. JA's anger at professionals was difficult for services to manage and made some professionals feel intimidated. It can be seen that the relationship particularly with adult social care had completely broken down and some suggested this was beyond repair. JA's son told the author that he suspected this was particularly so after the incident where JA believed that a social worker had impersonated a district nurse, as well as removal of appliances. Likewise, the money removed during the clean was also an issue for the family.

7.69. Continuing to try and enforce services onto JA was a risk due to the potential of breaching her human rights under article 8 (Right to a private and family life). Despite this there was no formal stepping back by services. There is no policy or guidance related to this either from a single or multi agency perspective, therefore it was not considered as a possible way forward.

7.70. In order to consider this, it would have to be undertaken following full risk assessment, involve all agencies, agreed with the person, and formally drawn up with legal support to ensure it was within legal frameworks.

7.71. Any type of removal or stepping back of services must always have the proviso of how often a service can 'check in' with the person as well as agreeing the circumstances under which a person might want to start receiving services again and that a stepping back agreement would never be used as a reason for not providing services in the future. Undertaking this may give the person some time to reflect and professionals some release from the pressure that they often feel under.

7.72. It may be that the local authority might want to seek an application for inherent jurisdiction in the High Court to ensure that there is nothing else that could be tried and that to continue doing so would lead

to a breach of human rights.

7.73. This process could be managed through the SACCG. In effect this would follow up from agreeing and contracting care plans as discussed previously, i.e. if a person did not want care or failed to engage in the care plan that had been agreed, discussions could move towards stepping back services where a person may be challenged on not being compliant with an agreed care plan.

7.74. In reality, this is what happened in the last year of JA's life, but it was not formally agreed, recorded or underpinned with legal advice.

7.75. In considering learning here it appears that where there is a continual refusal of services and there is no ongoing risk to others, that there might be rare occasions where it is agreed by all that services should be stepped back.

Learning Points:

- Where services are finding no resolution to difficulties in engaging a person, fully risk assessed stepping back of services may be an appropriate way forward.
- Stepping back of services requires a formal legally underpinned process that recognises professional accountability and the rights of a person to decline services.

Support and supervision

7.76. The final section within this analysis, relates to the provision of support and supervision for staff working in very difficult cases. There is good evidence of teams and services supporting each other, not only within agencies but also across agencies. Positives in this case were that there was no element of blame between organisations and no negativity between services. This should be celebrated.

7.77. It was discussed in the workshops that whilst some professionals may openly admit to struggling, there are some who may feel that to admit this is evidence that they are failing. Most organisations have in place methods of supervision, it may help the SAB to understand this in relation to complex cases.

7.78. Support comes in many guises, from informal conversations with peers to more formal seeking of managerial support and supervision. Professionals in this case sought various levels of help and support but it is identified that nothing particularly made a difference to how they felt, with some citing this case as very stressful.

7.79. The well-being of professionals is constantly being reviewed with a recognition of the issues of burnout. This is even more of an issue at the time of writing this report as the country is facing a pandemic.

7.80. There are various methods put forward as of use in the future that could help validate professionals' feelings and by doing so can lead to innovation and ways forward:

- Multi agency group supervision to include all services that are working with an individual, facilitated independently of the case.

- Multi agency peer support sessions.
- Management debriefing.

7.81. Learning therefore relates to a more collective approach to supervision when cases are difficult.

Learning Points:

- Various methods of supervision are beneficial in difficult and complex cases. Consideration should be given to multi agency supervision, independently facilitated.
- Seeking support and supervision should not be identified as negative but be seen as a vehicle to support the role of the practitioner further.

8. SUMMARY AND CONCLUSION

8.1. There is no doubt that this case was frustrating not only for the professionals but for JA and her son.

8.2. Many professionals tried very hard to offer support and treatment for JA, and support for JA's son as her carer. Nothing that was tried resulted in a mutually respectful or collaboratively negotiated care plan with JA's wishes and feelings at the centre.

8.3. It is very clear to the author that the relationship between adult social care and the family broke down many years previously and was unlikely to be repaired.

8.4. Professionals spent many hours searching for reasons for non-engagement such as mental disorder and/or mental capacity issues. Professionals appeared not able to accept that this was an adult with capacity to make her own decisions who had intact mental health but was refusing the services and treatments on offer unless under her own terms. Practitioners felt that they had no options other than to keep trying.

8.5. JA became notorious and her reputation for being difficult to work with was known across many professionals. This had a negative impact on anyone who would then be allocated to work with her.

8.6. The voice of JA was clearly saying 'no' to services, but this did not result in formal withdrawal of services in a planned and legal way.

8.7. This review accepts that relationships were broken but does provide learning for moving forward with working with those that are hard to engage and particularly where services are only just becoming involved.

8.8. It is these areas of learning that therefore lead to recommendations for improving and strengthening practice.

9. RECOMMENDATIONS

9.1. The findings identified above have been included in learning points throughout this report and lead to recommendations for improvement.

9.2. Where agencies have made their own recommendations, BDSAB should assure itself that those actions to strengthen practice and systems are underway.

9.3. The following multi agency recommendations are made to the BDSAB as a result of the learning from this review:

1. Self-Neglect and Hoarding

BDSAB should refresh and relaunch the Self Neglect and Hoarding policy to include learning from this review i.e. to include:

- Information regarding reasons and impact of hoarding behaviours and impact of removal of belongings
- Understanding history of the person
- Building trust and relationships
- A framework protocol for 'Stepping Back' Services that takes account of the learning points following para 7.75
- References and links to SACCG
- Importance of support and supervision

2. Safeguarding in Complex Cases

BDSAB should refresh and relaunch the Safeguarding Adults Complex Case Group guidance to include:

- Formalising the document by adding a governance front sheet e.g., Date, version control etc., introduction, SAB badged, and published on SAB webpage.
- Ensuring that there is clarity that attendance and presentation of a case can be by more than one agency, thereby multi agency approach is maintained within the meeting from those key frontline practitioners.
- Ensuring that minutes are filed within patient/client records across all involved agencies.
- Exploration of joint recording systems across agencies for complex cases.
- Clarity that there is addition to 'scope of cases' regarding those where an up-to-date assessment is not possible due to no access/no engagement (or adding that type of case to scope of cases).
- Adding stepping back of services to scope of cases as a must when this is being considered for non-engagement.
- Consideration of legal and housing representation either for all or 'as required' cases (legal would like this as an options appraisal for their current service review)
- Consideration for professionals in complex cases to be supported via multi agency support and supervision.

3. General Learning Briefing:

BDSAB to consider how best to disseminate all the learning points from this SAR. Consideration should be given as to methods that may accommodate different learning styles such as 7-minute briefings, video, podcasts etc.

To include making safeguarding personal, person centred care agreed with service user, contracting for care in difficult cases, importance of gathering history.

Appendix One:

Safeguarding Adults Review JA
Terms of Reference and Scope

1. Introduction

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

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

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

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

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

Condition 2 is met if—

(a) the adult is still alive, and

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

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

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

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

(b) applying those lessons to future cases.

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

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

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

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

2. Case Summary

Concerns were raised in January 2020 following a welfare visit that JA who was in her early sixties. JA had not been seen or heard from since before Christmas. The Police forced entry to the property and found J deceased. Her son, who was 37 at the time was still living in the property. It was reported that J had been dead since October 2019. her JA's son was held in custody for 24 hours for prevention of lawful burial and the property was closed as a crime scene. J and her son have been known to Adult Social Care since March 2012 due to concerns about their wellbeing in relation to the condition of the property i.e. hoarding and self-neglect. J was restricted in her mobility and had a diagnosis of multiple sclerosis, osteoarthritis and untreated diabetes.

3. Decision to hold a Safeguarding Adults Review

The Safeguarding Adult Panel of the Safeguarding Adults Board met on 23 April 2020. It was agreed that the criteria for a Safeguarding Adults Review were met and made a recommendation to the BDSAB Independent Chair that there was likely to be learning in the way that agencies worked together to safeguard JA. The Chair of the SAB endorsed this decision on 13 May 2020.

4. Scope

The review will cover the period **from approximately a year prior to the finding of J.** The flexibility of the start date is to ensure any key information immediately prior to January 2019 is not excluded. Key background history and information will also form part of the review that will inform the more contemporary elements of JA's life.

5. Method

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

Due to the National Covid -19 pandemic response, BDSAB chose a methodology engage with frontline practitioners and their line managers through a series of workshops undertaken using virtual meeting technology. Each workshop will focus on one or two themes and be set the task of exploring the themes and answering questions. The themes will be identified from the chronologies and other reports that have been undertaken by agencies. This will lead to identification of areas for learning and improvement.

This SAR will be undertaken from a strengths-based approach, identifying strong practice that affords learning for practitioners as well as where practice may need to be strengthened. Strong Practice will be shared as learning along with areas that lead to learning and recommendations.

Themes for exploration in workshops will include the following agreed areas**:**

- **Assessment, Care and Review (both individual agency responses and multi-agency working)**
- **Mental Capacity Act**
- **Family Relationships and History**
- **Carer Role and support**
- **Complex Case Panel as a System**
- **Effectiveness of the Safeguarding and Escalation Systems**

6. Independent Reviewer and Chair

The named independent reviewer commissioned for this Safeguarding Adult Review is **Karen Rees.**

7. Organisations to be involved with the review:

- Local Authority,
- Clinical Commissioning Group (CCG),
- Mental Health and Community Services Trust),
- The Hospitals NHS Trust
- Police.
- Fire Brigade

8. Family Involvement

A key part of undertaking SAR is to gather the views and experiences of the family and share findings with them prior to finalisation of the report. Adult J's son will be invited to be involved with the review.

9. Project Plan dates: (Due to the current national pandemic response, these dates are flexible in accordance with the needs of the process, reviewer and local organisations)

1.	**Scoping Meeting**	**7/10/2020**
2.	Terms of Reference updated	8/10/2020
3.	Information sent to Reviewer	8/10/2020
4.	Reviewer prepares for workshops	Four weeks after receipt
5.	Distribution of workshop documents to all Learning & Reflection Workshops attendees	03/12/2020 (approx. but at least one week ahead of workshop)
6.	Learning and Reflection Workshops	8th/10th/15th/17th December 2020
7.	V1 SAR Report to all Workshop Attendees	29/01/2021
8.	Feedback from V1 report to Reviewer	12th February 2021
9.	V2 circulated to panel	26th February 2021
10.	Panel meeting	TBC

11.	V3 To panel	TBC
12.	Panel Meeting to formulate Recommendations and Action Plan	TBC
11.	Final Draft Report to board	TBC
12.	Presentation to SAB	April 2021?