Doncaster Safeguarding Adults Board
Safeguarding Adult Review

Adult SAMMY

Report commissioned July 2022

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Independent Reviewer

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1. Sammy's Story

1.1 – Sammy was 48 years old and was described as having a great sense of humour, kind with a mind of her own. She loved her dog. Sammy had a close relationship with her sister when they were younger and with her parents. The family lived near each other in a community where neighbours helped each other out.

1.2 Sammy was a very intelligent person who would post long messages on Facebook commenting on current affairs and political matters. Sammy may have been transgender[1] or as her family understands was confused about her gender. It may be the case that Sammy was working towards living openly as a transgender person as her dress, change of name and presentation appeared to suggest this.

1.3 – Sammy had difficulties communicating over the phone and she found it difficult to trust others. She was vulnerable and there were several police call outs for her as a victim of crime. She also had several offences recorded against her in police records. At the request of her family, we will refer to Sammy as her/she throughout this report.

1.4 – Sammy struggled in maintaining her home, had difficulties with forming and maintaining relationships with others and she was potentially subject to exploitation by adults who posed a risk to her. She did have neighbours that would support her, but they had concerns of Sammy's suicidal ideation and that she had shared plans of taking her life. The reviewer saw photographs of when Sammy was happy, her wedding and some happy moments in her life when life was good for her.

1.5 – Sammy's childhood was impacted by abuse. Children's Social Care became involved, and she was briefly taken into the care of the Local Authority because of experiencing sexual abuse.

1.6 –It is understood by both Sammy's family and professionals that this abuse had a significant influence on her. It is understood that Sammy felt that her needs were not being prioritised.

1.7 – Sammy's sister shared many memories of them growing up together and said that they had a close relationship when they were younger. As they grew older, they had their own lives.

[1] At the request of her family, the subject of this review will be called Sammy and the terms She/her will be used where appropriate.

1.8 – Sammy's mother sadly died in 2021 during the covid pandemic. Professionals believed that Sammy's relationship with her family was complex. The family's view of the relationship differs, and they have said that Sammy's kept in touch although they did not always see her regularly.

1.9 – Sammy sadly died in June 2021 in her home due to misadventure (findings from the Coroner's Report). Sammy had several physical and mental health needs. She experienced a multiple level of illnesses including having difficulties with her back, and problems with her eyes. Sammy was diagnosed with psychosis, emotional disorder and depression in August 2018.

'When Sammy was a little lost, she would go to her parent's garden at any time day or night,' said her father smiling and remembering her.

1.10 – Sammy was one of three siblings. She lived near her family with both her parents and sister's home almost walking distance from her own home.

1.11 – In considering her experience of services there are a few quotes paraphrased from records seen by the reviewer.

Sammy had said that at times "she was not being helped… I have received NO help and feel nobody understands the real issues and despite asking for help NOBODY is listening and haven't been for years.

I DO know that I am currently mentally impaired and even need help from my neighbour to write this e-mail otherwise it will just be another issue that is misunderstood and the real issues unaddressed.

Nobody helped when my dog was run over.

1.11 – The coroner's report concluded that she died by misadventure. Records held by professional indicate there were concerns about suicide ideation by those working with Sammy.

1.12 – The Doncaster Safeguarding Adults Board (DSAB) initially identified areas of concern relating to suicidal ideation and self-neglect as key areas requiring a Safeguarding Adults Review.

2. Purpose of the Safeguarding Adults Review

2.1 – The purpose of this SAR is to gain, as far as is possible, a common understanding about the circumstances surrounding Sammy's death and to enquire about how agencies worked individually and collectively to support Sammy's needs.

2.2 – The Care Act 2014 section 44 confirms that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when there is a concern about an adult in its area with care and support needs.
2.3 – The Care Act section 44 also gives SABs the discretionary power to arrange a review of any other case involving an adult in its area with needs for care and support.

2.3 – A SAR should analyse what happened and suggest how practice could be improved.

2.4 – Therefore, this review is about '*learning and not blaming*' and the review has been carried out in line with DSAB SAR Policy. The review aims to highlight good practice, areas for learning and for improving future practice by making recommendations to the DSAB.

2.5 – DSAB considered Sammy's[2] case after she sadly died when she as 48 years old. The SAR was commissioned because it was agreed that the circumstances surrounding Sammy's death met the Care Act Section 44 criteria for a mandatory Safeguarding Adults Review.

2.6 – The DSAB followed the Care Act 2014 requirements which state that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) –

"*When an adult in its area dies as a result of abuse or neglect, whether known or suspected and there is concern that partner agencies could have worked together more effectively to protect the adult(s)."*[3]

2.7 – The Care Act 2014 also requires that Safeguarding Adult Boards commission a SAR when an adult with care and support needs has died and the Board –

"*Knows or suspects that the death resulted from abuse or neglect, whether it knew about or suspected the abuse or neglect before the adult died."*[4] This SAR has been commissioned in line with statutory guidance by DSAB.

[2] Care Act 2014.
[3] Doncaster Safeguarding Adult Board information quoting Care Act 2014.

2.8 – In line with the Care Act 2014 requirements, DSAB has commissioned an independent author this Safeguarding Adult Review (SAR) to consider the risks, needs and circumstances of Sammy's death.

2.1 The Reviewer.

2.1.1 – The multi-agency panel commissioned an independent author to complete the report – Kanchan Jadeja - an independent social care consultant. She has authored Safeguarding Adult Reviews and Local Safeguarding Practice Reviews. She is currently a reviewer for the National Child Safeguarding Practice Review (Department of Education).

2.1.2 – She is a Department of Education approved Improvement Adviser for Local Authorities in Children's Social Care.

2.1.3 – Kanchan is a qualified social worker and at various points in her career worked at leadership and improvement roles in Local Authorities and regional government.

2.1.4 – She has expertise in safeguarding children and adults. She has worked in a Whitehall Government Department, leading on youth policy and safeguarding (now - Department of Education). She has contributed to safeguarding work in the voluntary sector. She was the chair (and later President) of the National Council of Voluntary Youth Service and is currently the safeguarding trustee lead for LEAP, a National Youth Charity.

2.1.5 – The DSAB is keen to explore how agencies work with adults who present with multiple needs but have difficulties in communicating their own needs.

2.1.6 – The following agencies had regular contact with Sammy:

- St Leger Homes
- South Yorkshire Fire and Rescue
- South Yorkshire Police
- City of Doncaster Council, Well-being Team
- Rotherham Doncaster and South Humber NHS Foundation trust (RDASH)

2.1.7 – Other agencies that are part of the Case Review Group and have been part of this review:

- Integrated Care Board (ICB)

- Doncaster Bassetlaw Teaching Hospital (DBH)
- City of Doncaster Council, Adult Social Care

3. Terms of Reference and Key Lines of Enquiry:

3.1 – The focus of this review is to gather evidence about practice carried out with Sammy, analyse the effectiveness of multi-agency working and consider whether robust systems are in place to identify and respond to concerns of suicide and self-neglect for Sammy.

3.2 – The findings will be used to provide learning for services.

The following key lines of enquiry and Terms of Reference have been agreed by DSAB:

Terms of Reference.

The responses to the number of safeguarding concerns raised by different agencies and how these were responded to and fed back.

Was the risk of suicide communicated to agencies involved with Sammy?
Would a different response have been received if this had been escalated?

Is there a link between self-neglect and suicidal thoughts?
Was this exasperated due to the condition of the property?

The arrangements for information sharing, risk assessment, safety planning given Sammy's mental health concerns.

The effectiveness of current multi-agency processes to protect adults at risk of self-neglect.

Whether communication with the adult at risk and professionals was effective given previous safeguarding concerns.

Explore involvement of agencies Sammy pre-18 and what support was accessed by Sammy.

What impact if any did Sammy 's childhood have on presenting concerns in adulthood?

4. The Review Process and Methodology.

4.1 – The review has been carried out in line with Doncaster Safeguarding Adult Board, Safeguarding Adults Review Policy. The review follows the methodology outlined in the document. The first part of this process was for the panel to agree Terms of Reference.

4.2 – The review relied upon input from two key groups of local professionals, the Case Review Group (CRG) and the Practitioners' Group with considerable support from the DSAB, especially the Chair and Board Manager and Deputy Manager to engage Sammy's family in the review.

4.3 – The Case Review Group brought their knowledge of how local services operate, provided input about local service structures and contributed to confirm the key learning themes. Professionals provided additional information when needed to dig deeper into some relevant issues to better understand what happened to Sammy.

5 steps were involved:

4.4 – **Firstly,** chronologies prepared by agencies involved with Sammy were made available to the author, and these were considered to identify patterns of need, risks and circumstance for Sammy, how these were responded to and to consider any gaps in information.

4.5 – The chronologies have provided a window into how timely services responded to Sammy's needs and provide information for learning within the partnership, to identify any areas of good practice and how the partnership could have improved practice to safeguard Sammy.

4.6 – **Secondly,** agencies were asked to review their own records for gaps in information and either complete an Independent Management Review or chronologies as requested.

4.7 – The Independent Management Review included the agency's own views about their strengths in practice and areas for learning and improvement. Where there were concerns about practice, individual agencies took action to address these.

4.8 – **Thirdly,** a practitioner event was led by the reviewer and attended by key agencies to discuss the areas of practice. The discussion was helpful in reviewing the areas of good practice and areas for improvement and learning.

4.9 – The practitioner event provided a good opportunity for practitioners to share information about work carried out with Sammy, identify any gaps in their understanding of her need and the interrelationship between different professionals and their work with Sammy.

4.10 – The discussions focused on multi-agency practice and areas for learning. Individual issues were followed up with professional reflective discussions about practice and how it can be improved.

4.11 – **The fourth step** was to gather information about Sammy's lived experience. Discussions held at the initial panel meetings identified there was a gap in knowledge and information about the services understanding of Sammy's needs.

4.12 – **The fifth step** was to meet with Sammy's family members. It took some time to organise the meeting with the family and this has delayed the completion of this review.

4.13 – Meeting Sammy's family members on four occasions to provide a thorough understanding of her life experiences, and their views, wishes and feelings about the work that was carried out with Sammy. Their input has been invaluable in this review. They have shared key information about Sammy's lived experience, relationships and life journey from their perspective.

4.14 – The methodology and timescales in the completion of the review has been impacted by gaps in information, what happened to Sammy, her involvement with agencies, and her engagement with her family. There were circumstances that delayed the initial engagement with the family.

4.15 – The Chair of the CRG and the Board Manager and the reviewer agreed that time should be provided for the engagement with the family to be meaningful. It became apparent here there were differences in the family's understanding of what happened to Sammy compared to information provided by agencies.

4.16 – There were several meetings held with the family, the last meeting held was between family members and some panel members. The purpose of this meeting was to provide the family with the opportunity to hear first-hand from those agencies who attended about what happened to Sammy and have their questions answered.

4.17 – Not all questions were resolved but processes were put in place to follow up any outstanding enquiries. The family requested that the Sammy's to be used for this review and for her to be referred to as 'she' and 'her.' This request has been followed up in the review.

5. Practitioner Group Themes

5.1 – The Practitioners' Group comprised of professionals with direct practice experience in working with the cohort of adults like Sammy that the review wanted to understand. Their input helped the independent reviewer to test out ideas.

5.2 – The independent reviewer facilitated the practitioner group online to discuss the areas of practice highlighted by the agency reports.

5.3 – The discussion was very rich in reviewing the areas of good practice and a good opportunity to understand the interrelationship between different professionals and work of different agencies including their impact on Sammy. The discussions focused on multi-agency practice including:

5.4 – The overarching theme to test the confidence of professionals in working with self-neglect and suicide ideation for safeguarding adults with complex needs.

5.5 – How agencies responded to the needs of adults who have Mental Capacity and have care and support needs.

5.6 – How Sammy was supported to manage her day-to-day life (which she found difficult) including maintaining her home by cleaning and clearing her environment of clutter and dangerous equipment, managing with food and asking for support when she needed it.

5.7 – What was known or not known about the impact of Sammy's mental health and/or capacity and diagnosis.

6. Findings

6.1 Key Episode 1 - June 2018 to September 2019.

6.1.1 – The first key episode is from June 2018 to Jan 2019. In June 2018, a request was made for Sammy to be assessed for a Care Act Assessment because of self-neglect, poor hygiene and being diagnosed with psychosis. This referral was made by the Community Mental Health Team (RDASH).

6.1.2 – When a community mental health colleague carried out a follow-up home visit, Sammy's bungalow was clean and tidy and there were no concerns reported. Sammy's circumstances both in mental health and home conditions had improved and in August 2018 was told that she was discharged to mental health services as there were no further immediate concerns.

6.1.3 – Two months later in October 2018 Sammy told the St Leger Homes, Housing Officers that she was feeling suicidal, home conditions were found to be poor when two officers visited her home. These concerns were observed by an officer from St Leger Homes about Sammy's self-neglect and well-being. These concerns were raised with the Single Point of Access (RDASH)

6.1.4 – The housing officers made the assessment that Sammy's house was in poor condition. There was rubbish in all rooms, it was believed that rodents were in the property and there were clothes everywhere. Sammy was sleeping in her living room because the conditions of the other rooms were very poor. The housing officer believed that at this time, Sammy was feeling lonely within her home.

6.1.5 – As a result of Sammy struggling with maintaining her home it was agreed with her that a referral would be made for sheltered accommodation where she would have in house and regular support for her needs, risks and circumstances.

6.1.6 – St Leger Homes were contacted to provide sheltered housing for Sammy. However, following the referral and assessment, if was agreed that Sammy did not meet the criteria for sheltered housing.

6.1.7 – In December 2018, when assessed by CMHT using the FACE (Functional Analysis of Care Environment), there was no evidence of hallucinations and Sammy was assessed as at low risk of self-harm. Sammy was not taking medication for physical conditions, and this was causing her pain. At this time, there were concerns for Sammy's wellbeing, her home conditions, she was not taking her regular medication, and she had missed appointments for therapy sessions because there was no one to look after the dog.

6.1.8 – Sammy was actively working with staff from the community mental health team and latterly St Leger Homes housing officers. Sammy was also active in attempting to ensure that she received her benefits, especially to retain her car and therefore she accepted support to do so. Sammy also attempted to keep her home clean with some success at times. Although Sammy had asked for a review of her medication and was keen to work with medical professionals, she did not attend booked medical appointments and eventually stopped taking her prescribed medication.

6.1.9 – In January 2019, CMHT (FACE) assessment was completed. A Crisis Plan was also completed, and Sammy's Care Plan was reviewed and updated. Sammy agreed to therapy sessions and discussed moving towards transferring care to her GP. At this time, there was no evidence of hallucinations and was low risk of self-harm.

6.1.10 – In April 2019, Community Mental Health sent an appointment letter to Sammy for attendance to a therapy group. There were follow-up calls to confirm her attendance, but there was no answer. Sammy did not feel able to attend the therapy group on 29th April. The Community Mental Health Team attempted again in May 2019, there was no answer. A home visit was carried out by the Community Mental Health Team on 20th May, with no answer and Sammy's curtains were drawn. Sammy was seen later that day and were told by neighbours that Sammy was not taking her medication. Sammy was discharged due to non-engagement of

therapies and doctor's appointments as per Disengagement policy. A letter sent to Sammy's GP providing transfer information.

6.1.11 – In August 2019, Sammy attended the Emergency Department a Doncaster and Bassetlaw Teaching Hospital. Sammy was unable to open her eye after blowing her nose. Following this incident, she was referred to the Ambulatory[5] care for a further check-up. She had all her appropriate investigations and asked to return following day. The next day, Sammy returned to the Ambulatory care to review her investigation and receive her results. Further tests were requested, and these further tests were completed, her condition was to be monitored.

6.1.12 – In September 2019, Sammy had an Ophthalmology outpatient appointment, but she was not able to attend. A letter was sent to her GP about the outpatient appointment and the treatment she had received. All appropriate processes were followed in relation to this treatment and follow up appointments.

6.2 Key Episode 2 - Jan 2020 to April 2020. (First COVID 19 lockdown).

6.2.1 – From Jan 2020 to April 2020 (first COVID 19 lockdown), Sammy lived in St Leger Homes property with her family nearby. To stop the spread of Covid 19 people were restricted with who they could visit. Nationally this has impacted communities with accessing services as well as feeling isolated. Sammy would have been affected at this time and may have had an impact on her mental health.

6.2.2 – At this time Sammy informed the Wellbeing team that she was struggling with her finances and with maintaining and keeping her property clean and tidy. She received support from the Wellbeing team and St Leger Homes, housing officer and continued to engage with her. There was some good practice from the housing officer. This was positive because they had made a referral for dangerous smoking for Sammy to South Yorkshire Fire and Rescue (SYFR) to keep Sammy safe.

6.2.3 – This was important at this time during COVID when there were few professionals available to regularly consider home health and safety with Sammy.

6.2.4 – SYFR were swift in responding to the referral by placing fire alarms in the property and officers asked Sammy whether she was open to the adult social care. She told them that she was not.

6.2.5 – When they were informed by Sammy that she was not, they informed St Leger Homes that Sammy would benefit from a referral to Community Mental Health Team. This is good practice from SYFR both

[4] Ambulatory care is care or outpatient care is medical care provided on an outpatient basis, including diagnosis. Observation, consultation, treatment. This care can include advanced medical technology.

in completing the work in a timely manner and making appropriate investigations and referrals on their assessment of Sammy's needs, risks and circumstances.

6.3 Key Episode 3 - December 2020 to February 2021.

6.3.1 – Between December 2020 and February 2021, Sammy's needs were concerning to all practitioners involved in her care as there was an escalation in her needs. It was later discovered that she was at risk of financial exploitation and there was a question as to whether she was using illicit drugs. These concerns were raised by workers who attended her home; however, Sammy denied any issues and no further action was taken.

6.3.2 – In December 2020, two known male drug users were leaving the property when the housing officer jointly visited with SYFR. When they asked Sammy if she was being coerced into doing anything Sammy said she was '*fine.'* The home was very cold, and officers were curious about why this was the case. Sammy told the officers that she had no money for the gas and that there was no hot water. SYFR sent an email making a safeguarding referral and querying if Sammy was known to any of their services. A reply was received advising Sammy was not currently open to the service.

6.3.3 – Adult Social Care Safeguarding team responded to SYFR High Risk Coordinator via email: and a decision was made that no further safeguarding enquiries were required.

6.3.4 – On 23rd December 2020, St Leger Homes contacted South Yorkshire Police stating they were concerned Sammy was not mentally fit to drive and had been slurring potentially from substance misuse but that she had a valid license. South Yorkshire Police did respond that no crimes were confirmed at the time and no action was taken.

6.3.5 – Following this, St Leger Homes and SYFR made a safeguarding referral and contacted mental health services because of Sammy's vulnerable presentation. Both organisations were concerned about Sammy driving in the mental state she was in, and this could have caused a fatal accident for her or others on the road.

6.3.6 – The home conditions remained unchanged during a significant episode in which Sammy threatened to take her life. Two staff members from St Leger Homes, along with SYFR, responded to the crisis. The Single Point of Access (SPA) Crisis Team was contacted.

6.3.7 – RDASH Crisis Team - The RDASH Crisis Team provide 24-hour crisis support to the residents of Doncaster. The Crisis team have a 4-hour response time to referrals via the Single Point of Access (SPA). Initially referrals are triaged via the telephone. The triage will identify

whether face to face assessment is required to complete a full biopsychosocial assessment. If following a triage, a patient requires referral to other services, this will be facilitated, and the involvement of the crisis team ends. From 9pm to 8 am the crisis team cover the liaison psychiatry service based at Doncaster and Bassetlaw Teaching Hospitals (DBTH) which offers advice and liaison with DBTH retaining clinical responsibility. During the night hours the crisis team are not commissioned to attend any assessments in the community. If a 999 service calls the SPA and needs to speak to a crisis professional urgently, they are put through to a clinician. The crisis team is not an emergency response team and cannot replace the role of the 999 services They do not have the powers to remove someone from either a public place or their own homes by use of the Mental Health Act or the Mental Capacity Act.

6.3.8 – During this incident, the SYFR officer present was with Sammy when she expressed her desire to take her own life. Sammy indicated to the officer that if they left, she would indeed take her own life. The officer was understandably concerned about Sammy's mental health. The Crisis Team responded and spoke over the phone to Sammy, who said that she was feeling better and that she "*wasn't going to do anything."* This was the second incident of suicide ideation since August 2018. There is no evidence of any follow up after this. This was recorded as potentially an isolated incident and not followed through by agencies, including the Crisis Team. No Mental Capacity Assessments were completed at this time.

6.3.9 – An ambulance was called following this incident, and Sammy did not want to attend hospital because she did not have anyone to look after her dog, but assured officers that she was fine, and they left her home.

6.3.10 – Later, on the same day, the housing officer and City of Doncaster Council, Wellbeing officer attended the home to carry out a welfare check, they were advised that an ambulance had attended, and Sammy did not want to go to hospital.

6.3.11 – It later became clear that this was because there was no one to take care of Sammy's dog. The follow up of the incident is good practice. However, it is unclear whether a Mental Capacity Assessment was considered and whether there was a discussion about capacity and a multi-agency agreement about next steps in supporting Sammy; given that the visit was a crisis follow up visit.

6.3.12 – In January 2021, SYFR's High Risk Coordinator completed sharing information and sent it to St Leger Homes and Doncaster Council's Wellbeing officer. Subsequently, the Wellbeing officer contacted Sammy and noted that priorities of work with Sammy would be to support her with finances, cleaning and clearing her property.

6.3.13 – In February 2021, Sammy's circumstances deteriorated further, and she reported feelings of suicide and had scars on her wrists. There

were further concerns about the home conditions with the back garden and front room worse than officers had noted before. Empty bottles of alcohol were scattered everywhere, there were shopping baskets in the back garden. Records suggest that she was drinking excessively at times, but there is no evidence that Sammy's alcohol use was explored with her by any agency working with her. The DSAB may want to follow on this issue and consider how agencies work with adults whom they suspect may be misusing alcohol.

6.3.14 – The overall condition of the home and garden was viewed as poor. Although this deterioration was noted, no determined responses were taken by professionals who were aware of this situation. Those officers who regularly attended Sammy's home to provide support continued to do so, however, a more coordinated and assertive intervention was required to meet her needs. This includes mental health, suicide ideation as well as poor home conditions.

6.4 Key Episode 4 - March and June 2021.

6.4.1– The fourth key episode is the period between March and June 2021. Sammy was visited by a social worker following another safeguarding referral because there were concerns about financial exploitation and Sammy had not been taking her medication, the home environment had deteriorated. The social worker assessed that a SNARM[6] may be instigated, Sammy told the social worker and social work student that she was not in a good place and that she did not need any support at this time. She said that her mother had just sadly died, and she did not want a formal Care Act assessment but recognised that she did need support. It was agreed that a SNARM should be convened. It is not clear whether this was followed through.

6.4.2 – During the covid period other members of her family had formed what was known as a 'bubble'[6]at the time and she was not part of that bubble. This was because Sammy's mother's ill health, and for her sister and partner to take care of her parents.

6.4.3 – There were restrictions for funeral attendance, and Sammy could not attend the funeral because she was not part of the bubble and due to restriction in numbers attending funerals at the time. Family members recognise that this would have impacted on Sammy and caused her distress. However, it is positive that she asked for support from St Leger Homes housing officers, and the Wellbeing team and that she was aware that she was not coping well at the time. Although Sammy had said that she

[5] SNARM is Doncaster Self neglect and/or Hoarding Multi agency Risk Management Tool (SNARM).
6 A support bubble during covid that links 2 households to have close contact to restrict infection. https://www.gov.uk/guidance/making-a-support-bubble-with-another-household#:~:text=Once%20you%27re%20in%20a,if%20you%20are%20in%20one.

did not want a Care Act assessment, she did want support with some of the challenges she was facing at the time.

6.4.4 – In March 2021, a neighbour reported concerns to South Yorkshire Police that there was drug dealing from Sammy's home. There were known drug users and dealers leaving Sammy's home and her back door was always open.

6.4.5 – St Leger Homes officers were concerned that Sammy was being exploited or potentially cuckooed from her home. Housing officers suggested raising concerns about Sammy being exploited to police. There are no findings to suggest that this took place.

6.4.6 – Further work could have been carried out to pursue this and to intervene to understand what was happening in Sammy's home.

6.4.7 – Sammy's dog was very important to her, and records have shown that she did not attend appointments, prioritising her dog needs over her own medical and mental health needs. However, her own self neglect led to neglect of the dog and in April 2021, there were reports from neighbours concerned about of the treatment of the dog.

6.4.8 – Sammy's dog was removed by the RSPCA following CCTV footage. The RSPCA Inspector called the police for assistance to remove the dog from Sammy's home because they were neglected and beaten.

6.4.9 – Sammy was not at home nor seen during the removal of the dog. The removal of her dog would have been difficult for Sammy.

6.4.10 – In May 2021, there were further concerns about Sammy being exploited by a female who was living in her home. It was believed that the female was taking money from Sammy, who may have been financially exploited. In addition, Sammy's door was not locked leaving her open to strangers walking into her home. At this time, no SNARM was considered.

6.4.11 – A safeguarding referral was made by a call made from St Leger Homes housing officer to inform them about Sammy's vulnerability to strangers financially exploiting her. Overall, their assessment was that the risks for Sammy had escalated considerably.

6.4.12 – Sammy was found to be heavily drinking alcohol; the property was a 'mess.' As the back door was not locked, there were people walking in and out of her home. She was not protecting herself or her property and heavy drinking would have impacted on her physical and mental health. This was observed by the St Leger homes officer and South Yorkshire Police when they attended the home. Sammy's family told the reviewer her backdoor was never locked.

6.4.13 – There were further concerns and South Yorkshire Police contacted Sammy because of reports about her alcohol misuse. Sammy informed

them that she would go to ASPIRE (drug and alcohol service within RDASH), she was given information about Safe Space and the safeguarding referral was closed with no further action.

6.4.14 – When Sammy was asked about the male and female in her property, Sammy replied that they were helping her with cleaning her property. A joint home visit was carried out by St Leger Homes and South Yorkshire Police. This is good practice. A detailed vulnerable adult form was completed by the PCSO.

6.4.15 – Sammy's vulnerability to others was further evidenced when she reported that money had been taken from her bank account. When South Yorkshire Police discussed this with her; Sammy did not want to make a complaint. There were also further reports of suicide ideation and mental health needs. From the records available to the reviewer, it is evident that Sammy's needs were escalating, and this required an equal escalation in response from agencies.

6.4.16 – A further Vulnerable Adult form was submitted by South Yorkshire Police based on mental health needs and suicide ideation. In June 2021, one of Sammy's neighbours reported that Sammy had an open discussion with them about taking her own life and discussed details about how she proposed to do that.

6.4.17 – As Sammy did not have a landline and three attempts were made at contact by mobile phone which were not responded to, a letter was sent to Sammy by the Community Mental Health Team to encourage her to access support and therapy.

6.4.18 – On 27th June 2021, Sammy reported that her car had been stolen or was missing. Sammy had shared with the housing officer that she felt the Police did not respond immediately. However, Police records indicate that vulnerabilities such as suicide ideation were noted. Under policy procedures there was no crime in progress and no indication of immediate harm. A priority grading is considered where there is a degree of importance or urgency associated with the initial response. This may include but is not limited to public safety, concern for safety, person involved suffering significant distress or is deemed to be vulnerable, possibility of escalation in circumstance. Call handlers use the THRIVE model (Threat, Harm, Risk, Investigation, Vulnerability, Engagement. Under Vulnerability). The call handler assessed that Sammy was vulnerable due to how she presented on the call and mental health issues discussed with her.

6.4.19 – On this date Sammy sadly died. The coroner's verdict was that Sammy died by misadventure. Sammy's family believe that she did not take her own life, and others were involved in exploiting her vulnerabilities which sadly led to her death.

7. Family Involvement in the Review

7.1 – The Case Review Group, (CRG), and the Reviewer were very keen to ensure that Sammy's family members were contacted, their views sought and that they were provided with the opportunity to engage with the review. This took some time to arrange as most agencies had reported that Sammy's relationship with her family was strained and with her sister following the sad passing of her mother.

7.2 – The group agreed that the most appropriate route to contacting Sammy's sister was through a police officer who had contact with her. This was delayed because of various reasons that are outside the scope of this review.

7.3 – The Board Manager wrote a letter to family members asking them if they wanted to be involved in the review. Sammy's sister wrote back and arranged a time to meet with the Board Manager and the reviewer. Following the first meeting, Sammy's father requested a meeting with the reviewer and the Board Manager, this meeting provided additional and nuanced information about Sammy that was not known by agencies (such as her sexual orientation). In all there were four meetings with family members to ensure that their views and perspective about what happened to Sammy was a strength within this review.

7.4 – The family requested that the Chair of the CRG, Board Manager and the reviewer with members of the group have a discussion with them about some of their own views about what happened to Sammy and to listen to their views about learning for agencies. The reviewer, Board Manager and Chair met with family members and another meeting was held with additional CRG members and the family. This meeting took place and was very insightful for the family as well as agencies attending.

7.5 – Sammy's Father's note for review:

The reviewer met with the family and Sammy's father wrote a letter to the panel and reviewer – some statements have been paraphrased.

"My daughter's death was judged to be misadventure. I am writing this letter to explain why I know my daughter's death was a case of missed opportunities by 'services'…When I was told by the authorities that Sammy's home needed to be refurbished and that they could not fund this, although I am a disabled pensioner, I managed to scrape together the resources, call in favours and sort her property out for her".

My daughter had mental health needs and during covid she was left to her own devices. She had tried to take her life many times and she was not well. She was given notice to move from the house. She was seen many times but not much difference was made to her life.

On the day she passed, she rang three times that her car had been stolen and three drug users who came into her home and took her keys.

On the day that she passed, the way that I was told about her taking her own life was short and just a 5-minute[7] report because the officer had to go to three other calls. Noone has contacted me since she passed. I am not sure if you will read all of this, but I hope you do and if you do you will be the first to show respect to my daughter and or myself.

SAMMY's father.

8. Analysis of Key Practice Episodes.

8.1 – Sammy's early experiences of abuse will have impacted on her sense of self and self-esteem. [8]"*Sexual abuse in childhood can affect an individual's view of the world and their thinking, feelings and behaviour…. Research had identified a number of difficulties such as depression, substance misuse, establishing and maintaining relationships and suicidal behaviour* (Itzin, Taket and Barter Godfrey 2010).

8.2 – The impact of child sexual abuse (CSA) was discussed with Sammy's family and family members recognised that CSA would have had a profound impact on her. Practitioners working with Sammy had not sufficiently made this link. Information from Sammy's family has shed further light on why she may have felt isolated and distressed following her mother's death.

8.3 – Agencies working with Sammy felt that at times she was fine and therefore work with her was intermittent where she was open to agencies and when her home circumstances improved, she was closed to agencies. Professionals working with adults who have had a form of childhood trauma should be aware that this can present in nuanced and complex behaviours and provide support both to the individual as well as their families to understand the impact of the trauma.

8.4 – There was no one agency that knew all the information available about Sammy at the time. It is likely that Sammy would have received more assertive early and regular support and intervention for attending therapy sessions and for her overall mental and physical health, had agencies understood the underlying vulnerabilities at this time. Sammy's own priorities appeared to be a PiP appeal, looking after her dog, and concerns about her car.

8.5 – The review has considered work carried out by all professionals with Sammy and there are areas of good practice where contact was made and there was a service provided to her. However, this was not

[7] A report was completed by PSD and the IOPC following a complaint regarding this. The IOPC decided this could be subject to a Local Investigation. The investigation conducted by the Professional Standards Department highlighted that the Officer delivering the warning reported that he spent 20-30 minutes at the address and that further Officers attended at a later date and spent around an hour with him.

[8] The influence of child sexual abuse on the self from adult narrative perspectives. Krayer A.M; Gwilym,. H.M; Krayer A; Seddon D; Robinson C.A; Gwilym, H Journal of Child Sexual Abuse 29th January 2024.

consistent, and at times when she was particularly struggling. When Sammy was challenging her PiP, she became very distressed. On 27th June 2021 Sammy wanted to drive her car and was very distressed that she could not have access to her car because it was stolen. Although police did not attend to her home immediately after she reported her car lost, she was visited later that day. Her family understand that it took four hours for police to attend and have a view that this was not proportionate to her vulnerabilities. Sadly this is the same day that Sammy died.

8.6 – As evidenced in key practice episodes, Sammy had multiple needs and presented with different risks at different key practice episodes. She had mental health needs, presented with suicide ideation with her neighbours supporting her to keep safe. Sammy was prescribed medication for her physical conditions; she was not taking her medication which exacerbated her condition. Sammy was being potentially financially exploited as an adult. Sammy was supported by some committed officers who met her needs on an on-going basis.

8.7 – This could be queried with agencies about what they can do differently so that adults can access support even when they are not able to navigate the systems that are designed to support them.

8.8 – In her earlier adulthood Sammy was briefly married to a man, however, that relationship broke down. Although there were few practitioners working with Sammy who had a full understanding of her gender status, there were some practitioners who told the reviewer that although they had not been openly informed by Sammy, were aware that she may be transgender.

8.9 – Her family confirmed that she was working towards transitioning, however, the reviewer could not find any evidence this issue was fully explored by anyone professionals. This may suggest that further work is required to support professionals to understand and work with transgender adults who also have multiple vulnerabilities and needs. Sammy had told professionals that she had a baby that sadly died, her family have told the reviewer that this was not the case. There is information to the contrary, it was not possible to be conclusive about this issue. It would have been appropriate for professionals to be more curious about this and check out from records and verify this information. It is likely that at times Sammy was reaching out for support through this. There are no medical notes received by the reviewer that Sammy was pregnant and had a baby.

8.10 – The family members believed that Sammy was not a parent and had not given birth to a baby who later died. As professionals were not aware it is difficult to assess what work they could have carried out to support Sammy with this issue and the reasons behind why she had said that she had a child.

8.11 – There was no thorough assessment by any one agency of Sammy's needs. For example, SYFR contacted the Safeguarding Adults within City of Doncaster Council, making three calls about

concerns for Sammy. Other agencies such as RDASH, had assessed that there was no evidence of the concerns meeting the decision-making criteria defined in the Care Act 2014.

8.12 – There were many safeguarding referrals by South Yorkshire Police, SYFR services and St Leger Homes. The first referral recorded was in June 2018, when St Leger Homes made a referral to SPA because they were concerned that Sammy was low of mood, her bungalow was untidy, and they had financial arrears.

8.13 – This led to her being referred to Doncaster Council Wellbeing team as well as mental health services. Since this review, the practice in the Safeguarding Adults Hub has changed, the panel and review are assured that there are alternative approaches to support adults who do not meet statutory criteria. The DSAB may want to test this through an audit review.

8.14 – The question arises about the decision making and understanding about adult safeguarding as a shared language by all agencies working with Sammy.

8.15 – The two agency colleagues who visited her were clearly concerned that Sammy was at risk. The outcome of the safeguarding referral was no further action.

8.16 – A key issue in this review is about how staff trying to manage a crisis can be supported. This was highlighted by an incident where two members of staff were told by Sammy that when they leave, she was going to take her own life. The two officers took raised their concerns and were advised that it is up to them whether they stay in the property or leave. This issue led to many professional discussions about who identifies safeguarding concerns, whose responsibility it is to progress with the work to support adults at risk and how agencies work together to respond to support needs of front-line staff as well as vulnerable adults.

8.17 – The two members of staff stayed with Sammy, an ambulance was called and when it arrived Sammy made the decision that she would not go to hospital. This incident has highlighted a gap in support for adults at risk at a time of crisis. Equally, this question applies to staff and what support is afforded to staff attempting to support adults at risk. Further work is required to support staff who may not always be trained to manage risky situations and where a referral has ended in no further action.

8.18 – A wider discussion for the DSAB is who shares responsibility for adults who are understood to have capacity (as had been assumed for Sammy). This highlights the importance of who shares responsibility for adults who are understood to have capacity. There was no mental capacity assessment carried out. This review found that professionals could make better use of guidance (for example the SNARM) and legislation. In addition, practitioners could work better together to

develop and improve practice and promote health and wellbeing of vulnerable adults.

8.19 - There was another referral to adult social care and the outcome of the referral was for the Wellbeing team to continue to provide support for Sammy as they were involved with her. A safeguarding referral was pending but was due to be progressed when Sammy sadly died.

8.20 – It is worth noting and querying firstly whether appropriate thresholds were applied and secondly when an adult at risk is or likely to be at risk, there is clarity between agencies about criteria for assessment and safeguarding intervention. These are wider contextual issues for the DSAB to consider especially how they make use of the legislative and policy framework to manage engagement / non-attendance.

8.21 – A third issue is about the convening of multi – agency meetings. Where there are professional differences, a discussion should be held and if possible, a multi-agency meeting held to bring together information held by each agency about the adult. Practitioners could have made use of the SNARM process and policy. If this was followed up by all agencies the SNARM process and a multi-agency meeting would have been convened to better understand Sammy's needs, risks and circumstances.

8.22 – In case of Sammy, a number of referrals were made, the decision was to continue with support from Wellbeing team and by St Leger Homes. There was no escalation when referrals did not progress as would have been expected. In addition, it is not clear in the information available whether there were any multi-agency meetings to discuss her needs more holistically amongst professionals.

9. Learning from Analysis and Findings

9.1 – The learning from the findings draws on aspects of practice with Sammy. Furthermore, the reviewer has derived information of how local services work to support the development of the findings. The findings reflect meetings with Sammy's family.

9.2 – The reviewer has been reassured that many of the issues raised in this report have already been understood and agencies separately and together have acted upon some of the issues raised in this report.

1.	Is there a link between self-neglecting and suicidal thoughts. Was this exasperated due to the condition of the property.
2.	The arrangements for information sharing, risk assessment, safety planning given Sammy 's mental health concerns.

3.	The effectiveness of current multi-agency processes to protect adults at risk of self-neglect.
4.	Whether communication with the adult at risk and professionals was effective given previous safeguarding concern.
5.	Explore involvement of agencies pre-18 and what support was accessed by Sammy. What impact if any did Sammy 's childhood have on presenting concerns in adulthood.

9.3 – This approach provided a wider and relevant depth and are structured using the following questions and based on the Terms of Reference.

a) How did the findings and learning manifest in the case?

b) Were issues of self-neglect, suicide ideation and childhood trauma relevant in this finding?

c) Were issues of Sammy's transgender, equality, diversity and inclusion considered when working with Sammy?

d) What is the significance of this finding to the functioning of the safeguarding system?

9.1 Finding 1 - Is there a link between self-neglecting and suicidal thoughts. Was this exasperated due to the condition of the property?

a) How did the finding manifest in the case?

9.1.1 – Self-neglect is described as "*when a person being unable, or unwilling, to care for their own essential needs, it can cover a wide range of behaviour including neglecting personal hygiene, health or surroundings, refusal of necessary support and obsessive hoarding"* [9]

"[10]*Suicide ideation often called suicide thoughts or ideas, is a broad term used to describe a range of contemplations and preoccupations with death and suicide. There is no universally accepted consistent definition of suicide ideation…."*

9.1.2 – Research has shown that meaning in life reduces suicide ideation and emotional neglect "*brings suicide ideation."* Why does emotional neglect bring suicidal ideation?[11] The mediating effect of

[9] SCIE Self Neglect. 2018.

[10] National Library of Medicine. Suicide Ideation B Harmer, S Lee, T Duong, A Saadabadi Jan 2023.

[11] The mediating effect of meaning in life and the moderating effect of post-stress growth and suicide ideation. Author Weiwei Zhong, Qianrong Liang, An Yang, Ru Yan. March 2024 Abuse and neglect.

meaning in life and the moderating effect of post-stress growth. Sammy had adverse childhood experiences, was struggling with possible gender alignment, had mental health needs, professionals reported self-neglect and home conditions were poor.

9.1.3 – Self-Neglect is a category for adult safeguarding under The Care Act (2014) statutory guidance. The independent management reviews, chronologies prepared by agencies all indicate that Sammy was at risk and there was evidence of self-neglect.

9.1.4 – This was evidenced in the state of Sammy's home, in her not taking her medication, and being vulnerable to financial exploitation. The Key Practice Episodes show that whilst in 2018/2019 it did improve at times, from 2020 self-neglect was a constant feature in Sammy's life. Records provide information about home conditions which are described in graphic detail as being '*poor.'*

9.1.5 – Self-neglect and overall records show that Sammy had dog faeces on her floor, the dog lived in her living room (Key Episode 3), there were mice in her property. At times when professionals visited her home as not taken care with her personal hygiene. In particular, the SYFR had raised safeguarding referrals to adult social care on several occasions. They had attended to Sammy's home to make it safe and had contacted mental health services when they were concerned about her safety and wellbeing. Sammy's family understand that attempts to take her own life, Sammy is likely that this was a cry for help, and support for potentially deeper issues she was grappling with for example childhood trauma and mental health needs and depression.

9.1.6 – There is no evidence that the clutter scale was used to support Sammy. The multi-agency procedure Self-Neglect and Hoarding last updated in 2022, includes a clutter index rating scale.

[12]*A study explores the perceptions and experiences of community mental health workers who assess and manage the risk of self-neglect and severe self-neglect in people with serious mental health problems. The initial literature review demonstrated a lack of material on this specific subject."*

9.1.7 – This was a missed opportunity to collate information together and to better understand Sammy's the risks and vulnerabilities and to respond to them. There is no explanation found by the reviewer about why a SNARM was not considered. Sammy's needs did not meet the Section 42 threshold nor was any Mental Health Capacity considered.

[12] Working with people who self-neglect Research in Practice. Practice Tool. RIP 2020.

9.1.8 – Had all her needs, risks and circumstance been assessed more holistically, the response may have been to provide her with additional and consistent support although she did not meet the criteria for sheltered accommodation.

9.1.9 – The clearing and cleaning of her home was sadly linked to Sammy having had support from a woman and *'friends'* who may have exploited her. Her neighbours complained that adults known to take illegal drugs were coming into her home. Further professionals understanding about Sammy's relationship with her family may have improved practice with better understanding of her needs, risks and circumstances. Sammy chose to not involve her family to engage with services. However, a social worker supported Sammy's father to deep clean the property initially. It may have been possible to maintain this contact with the family and explore this as an option.

9.1.10 – This review has highlighted many areas for learning, for example ensuring, good communication between agencies, effective safeguarding through understanding a pattern of risks and needs instead of responding to individual incidents. The review has found information which demonstrates the importance of appropriate threshold decision making and considering alternative safety planning where threshold have not been met. Referrals were made, when necessary, but these were not always followed up or progressed. It is important to be more curious and find other means to communicate with an adult if they reply that they are fine when they are perceived by professionals as not. This is particularly important when the adult at risk is experiencing self-neglect and suicide ideation as was the case for Sammy.

[13]"*It is evident that suicide ideation present in a 'waxing and waning manner,' so the magnitude and characteristics fluctuate dramatically. It is critically important that professionals recognise that it is a heterogeneous phenomenon."*

9.1.11 – Furthermore, [14]*"thoroughly assessing and monitoring the pattern, intensity, nature and impact of suicide ideation of the individual and documenting this is important."* - Records and Independent Management Reviews illustrate this to be evidenced in working with Sammy.

9.1.12 – Sammy had told her neighbour she was going to take her own life, there was evidence of self-harm and planning for suicide This was 'waxing and waning.' The review has highlighted a need for training professionals on how to work with these behaviours.

[13] National Library of Medicine. Suicide Ideation B Harmer, S Lee, T Duong, A Saadabadi Jan 2023.

[14] National Library of Medicine. Suicide Ideation B Harmer, S Lee, T Duong, A Saadabadi Jan 2023.

9.1.13 – Sammy's significant needs may be faced by others in Doncaster. The Practitioner Event has discussed and has plans to work with vulnerable adults who face self-neglect and suicide ideation. Therefore, it is important that the strategic leadership reviews current practices to improve outcomes for vulnerable adults.

b) Were issues of self-neglect, suicide ideation and childhood trauma relevant in this finding?

9.1.14 – Issues of self-neglect and suicide ideation are core to this finding. Sammy's early childhood trauma is likely to have impacted her mental health and potentially the emotional distance with others. This isolation and inner struggle are likely to compound feelings of suicide ideation and overall mental health.

9.1.15 – There were occasions when Sammy told her neighbours and professionals that she wanted to take her own life. She was stopped in doing so by her neighbour on a number of occasions. The responses to suicide ideation and impact of self-neglect require thorough information sharing, plans to support that are owned by professionals as well as in Sammy's case her neighbours and clear safety planning.

9.1.16 – Sammy had considerable vulnerabilities from her childhood and early adulthood, and she struggled with daily living. She had reported that she was suicidal to different agencies and individuals at different times. There was one occasion when her presentation had concerned officers that her suicide ideation was imminent.

9.1.17 – The lack of recorded information and analysis of the impact of self-neglect and in Sammy's case home conditions makes it difficult to comment on the causal link between that and suicide ideation. St Leger Homes had provided consistent support to her, carried out home visits with other professionals to encourage Sammy to clear her home environment. Her vulnerabilities needed to be more trauma informed because of her childhood trauma of sexual abuse, alcohol misuse and mental health needs. Over the period covered by this review, Sammy had cleared her home environment and officers who attended her home reported that they had cleared clutter and cleaned her home with support from her friends. Sammy's family had also been involved in supporting her to clean, clear and redecorate her property at their own cost. However, towards the latter part of Sammy's life, there were signs of clutter in her property and Sammy self-neglecting by not taking her medication.

c) Were issues of Sammy's transgender, equality, diversity and inclusion considered when working with Sammy?

9.1.18 – Issues of transgender, equality, diversity and inclusion are often difficult to attribute to specific behaviours and mental health needs in adults with vulnerabilities.

9.1.19 – Sammy had experienced trauma as a child, had mental health needs, had some physical medical needs and was possibly working towards transitioning her gender. These issues highlight the intersectionality of her needs and therefore raise the question about how well professionals understood and worked with her from this lens of intersectionality. [15]

9.1.20 – Whether self-neglect and suicide ideation was exasperated due to the condition of the property when perceived from an intersectionality lens is difficult to assess.

d) What is the significance of this finding to the functioning of the safeguarding system?

9.1.21 – Learning for the wider safeguarding system is to consider the pattern of referrals made, to follow through and close the loop on issues of using the SNARM.

9.1.22 – For Sammy, professionals had not always perceived the high level of self-neglect in the suicide ideation that she presented with. There was considerable activity to support Sammy with home conditions. However, it is not clear whether the link between self-neglect and suicide ideation was made.

9.1.23 – For example, the completion of the SNARM and assertive action being taken when she said that she was now fine after informing professionals that she would take her own life after the officers left.

9.1.24 – Sammy had most contact with agencies involved in supporting her with her home conditions mainly to improve her home to make it more habitable and safer for her. These agencies were St Leger Homes and SYFR. Therefore, it is relevant to consider the key elements of the Care Act to understand what happened with safeguarding concerns raised by agencies about Sammy and with each other and the Local Authority.

9.2. Finding 2 - The arrangements for information sharing, risk assessment, safety planning given Sammy 's mental health concerns

[15] Intersectionality is the acknowledgement that everyone has their own unique experiences of discrimination and oppression. Womankind.org.uk 2019

a) How did the finding manifest in the case?

9.2.1 – In the Practitioner Event held with all agencies involved in working with Sammy. RDASH reported that there is a shared understanding about information exchange, and this is set out in an information sharing protocol which is signed by members of the DSAB.

9.2.2 – Agencies assessed that there are occasions when sharing information about Sammy's vulnerabilities and risks may have been overlooked. For example, when Sammy was discharged by RDASH, contact could have been made with the G.P for follow up appointments in the community. A letter was sent on 31st May 2019 detailing information transferring Sammy to the GP. Following good practice would include detailed clinical information of Sammy's needs.

9.2.3 – This approach meant that when risks were heightened other professionals were not aware that Sammy's situation had considerably deteriorated. Arrangements to manage risk and develop multi agency safety planning were missed.

9.2.4 – This information was not triangulated with information that was on record about Sammy's needs, risks and circumstances including self-neglect and suicide ideation. Each incident of escalation and multiple vulnerabilities presented by Sammy could have been viewed through a pattern of risk rather than isolated incidents.

9.2.5 – It is important to note that St Leger Homes and South Yorkshire Fire and Rescue evidenced communication and appropriate information sharing between themselves and other agencies. However, the variance in Sammy's mental health conditions meant concerns were responded to intermittently.

b) Were issues of self-neglect, suicide ideation and childhood trauma relevant in this finding?

9.2.6 – The risks of self-neglect and suicide ideation were noted by individual agencies learnt about on an incident-by-incident basis when they visited Sammy were shared. The agencies that followed these up with referrals were St Leger Homes and SYFR.

9.2.7 – In February 2021, Sammy's sister was concerned that she (Sammy) was attempting to source a firearm. Police were involved and took appropriate action. Other risks related to financial abuse when a friend of Sammy's took money from her bank account. Her home conditions were described poor having mice infestation, and risk of water contacting electricity in her shower room.

9.2.8 – It was reported that people known to take drugs may have exploited her and she was at risk of cuckooing.” Police found no evidence of this.

9.2.9 – Another key risk to Sammy is from her own isolation, feeling that she could not trust anyone and that she felt like giving up. On several occasions, she told neighbours and professionals she wanted to take her own life and that she had made plans. She attempted to source firearms, mentioned using gas pipes. This risk of suicide was known to many who lived near her or worked with her. There was no known safety plan specifically to address this.

9.2.10 – There was regular contact between some agencies which formed part of safety planning for Sammy. The Safeguarding Hub had recorded that the referral did not meet threshold and if home conditions did not improve, then a SNARM would be carried out. The well-being team visited Sammy with St Leger Homes. It was evident that the two professionals who visited her together knew Sammy's needs well. This links to the earlier point about multi-agency meetings but also the condition of home and history indicated self-neglect toolkit would have enabled practitioners to assess Sammy's needs, risks and circumstances.

c) Were issues of Sammy's transgender, equality, diversity and inclusion considered when working with Sammy?

9.2.11 – *"People who are exposed to discrimination and social exclusion based on. sexual orientation is at greater risk of developing mental health problems and lower mental well-being*…"[16]. Lower mental well-being is likely to have impacted on the state of Sammy's property. From information received in Independent Management Reviews, it is evident that there was a complex set of circumstances that led to Sammy's self-neglect and suicide ideation.

9.2.12 – There was little information shared and understood about Sammy's gender identity. She had not discussed this issue at length with any professional and there was no nuanced assessment of this issue from her perspective. The family's views about this were very clear. This is because of her appearance and the way she presented. The critical question is that, were workers confident in having these discussions as this may have made Sammy more vulnerable to being exploited.

9.2.13 – However, her family have reported that this was an area of need for her. Therefore, she required a multi-agency risk assessment, sharing of information and a safety plan that included all agencies to record and act upon when they met her.

9.2.14 – The Equality Act 2010 protects those with mental health needs as a protected characteristic under and Disability (including mental health needs). Public sector equality duty is the legal duty which public authorities have to follow. There is an expectation that the policies and

[16] Equality and diversity: findings from the Mental Health Fellowships between 2016-2019. Mental Health Foundation. Winston Churchill Memorial Trust. 2020.

procedures affect people with mental health needs.[17] Sammy's mental health, self-neglect and suicide ideation vulnerabilities and needs could have been better responded to.

d) What is the significance of this finding to the functioning of the safeguarding system?

9.2.15 – The Anti-Social Behaviour: Crime and Policing Act (Section 8) allows for closure orders to prohibit access (up to three months) to a property. Injunctions can also restrict who can enter a property. Breaking a closure order is a criminal offence punishable by imprisonment, meaning police can immediately arrest unwanted people found in a home with a closure order on it.

9.2.16 – It is unclear from the information available whether further investigation may have led to a closure order. Neighbours have reported that there were individuals in Sammy's home. Police have reported that the allegations that Sammy was a drug dealer were not substantiated but she may well have been victim to criminal exploitation. There was good practice evidenced in police sharing information and the filing of a vulnerable adult form to provide information about Sammy's mental health needs.

9.2.17 – A question arising from this review is what professionals can do when the vulnerable adult does not follow up on offers of support. Sammy had offers of therapy and did not take up this offer. She had several health needs, including her mental health needs but had not gone to her GP. The onus is on the adult to attend.

9.2.18 – When the adult feels lack of energy and motivation to take medicine and is presenting with the range of needs / risks that they did, then professionals can experience confusion and difficulty about what action to take. The wider safeguarding system could consider adopting a more personalised needs assessment when an adult who is assumed to have capacity does not take up the offer of support.

9.3. Finding 3 - The effectiveness of current multi-agency processes to protect adults at risk of self-neglect.

[17] Mind Website Equality Act 2010 and how it impacts on those with mental health needs.

a) How did the finding manifest in the case?

9.3.1 – The St Leger Homes housing officer was one of the 'front line' staff providing regular support for Sammy. South Yorkshire Police and SYFR were also involved in supporting Sammy regularly attending to her needs and visiting her at home. Doncaster Wellbeing team were involved to support Sammy and working with her. Individual agencies working with Sammy did share information and carried out joint home visits. Therefore, although a SNARM referral was not initiated, these visits provided wider perspective on Sammy's needs than single agency working.

9.3.2 – The first agency that St Leger Homes refers tenants who have mental health needs and are presenting with self-neglect is the tenant's GP. However, officers have reported to the reviewer that the response from the tenants tends to be '*what is the point' I might as well top myself...* they only refer them to others. Therefore, although vulnerable adults are referred to their G.P, the partnership feedback is that this service is rarely accessed. The GP is a key player in multi-agency working and providing information about adults at risk to other agencies. The DSAB will wish to pursue this issue and find solutions if it is prevalent across the partnership areas. What prevented Sammy from following up on appointments, going to her GP when Sammy needed to review her medication.

9.3.3 – When the housing officer contacted the Crisis Team in respect of Sammy and asked, 'what do we do? Shall we leave her or stay with her?' they were told that it was up to them. This put the onus on front-line staff to manage what to them felt like a high-risk situation.

9.3.4 – The front-line staff left when they felt assured that Sammy was not going to take her life. This is a key area of learning from this review, in that in the absence of specialist support services responding to the threat of Sammy taking her own life, front line practitioners in the community were left having to support her.

9.3.5 – In relation to Sammy informing officers that she will take her own life when they leave, the housing officer felt they had no option but to stay with Sammy as the situation and risk presented was high. They contacted the Crisis Team who advised to contact the police. When they contact police, then they are told to contact the crisis team.

9.3.6 – The panel discussions have been frank, and issues such as leaving front line staff to stay with an adult they are concerned may take her own life requires further follow up. The reviewer has met with agencies and this work has started but will need to be progressed by DSAB. Doncaster's adult leadership has positive plans in place to review services and some have carried out changes and learning from this review.

9.3.7 – Could more professional curiosity be exercised to drill down to her needs, make risk assessments, have these inform a thorough and holistic assessment of her needs and to create a multi-agency and workable plan

that is designed to meet her needs? That is, not to expect that she will follow through on appointments, and that she will be able to know when she is going to self-harm and contact people but to communicate with her so that she is able to vocalise her needs.

9.3.8 – It is important to note that in this situation, Police could have used their powers under section135 [18] as Sammy was in a private dwelling and suffering from a mental health disorder. Alternatively, the Crisis Team or an ambulance was used to provide immediate support to Sammy.

b) Were issues of self-neglect, suicide ideation and childhood trauma relevant in this finding?

9.3.9 – Sammy's presentation of self-neglect and suicide ideation was communicated to Adult Social Care through several referrals made. A discussion was held about specific concerns raised by SYFR about Sammy.

9.3.10 – This was good practice because St Leger Homes and SYFR had 'seen' the level of need and set out the areas they were concerned about. There was concern about life threatening hazards in Sammy's flat. However, as the Wellbeing team was already involved, the decision was made for them to continue working with Sammy and not to carry out a care assessment about Sammy's needs. The pattern of need could have been assessed thoroughly and communicated with all those involved with Sammy and all the range of risks (already set out).

9.3.11 – The receipt of safeguarding referrals seemed to have considered each referral as a 'one off' based on the individual risk at the time of the referral. This does not seem to have taken account of the history and chronology of events and there was no care assessment completed.

9.3.12 – It is not possible to evidence a holistic need assessment. In children's services, if there are several referrals in a given period of time, they carry out an assessment, this is an area for further consideration by adult services.

9.3.13 – Work by individual agencies may have underestimated Sammy's needs as there was no one agency that had carried out a detailed assessment of her need over time. This is especially important considering that she felt socially isolated and the impact of her childhood experiences on her as an adult.

9..3.14 – Sammy 'did not attend' several appointments with health services. The non-compliance could have been followed through and provided an opportunity for consideration of mental capacity act Assessment. This assessment was in part missed due to the absence of formal multi-agency meetings as outlined in safeguarding guidance. However, there was no mental capacity act assessment carried out to

[18] Section 135 give police the power to remove a person from their home, when they appear to be suffering from a mental health disorder to a place of safety.

understand her level of capacity and the impact of this in managing her finances.

9.3.15 – The DSAB will want to consider how else agencies could have communicated the importance of appointments to Sammy and perhaps given her a time to use creative methods to engage. Discussing may have provided an opportunity for intervention work with Sammy.

9.3.16 – There was an assumption that she would follow through on agreed actions. The question is, if there was a multi-agency meeting, would some of those actions have been followed up more thoroughly by agencies because they would have appreciated the wider vulnerabilities that they presented with. This practice was not in compliant with the self-neglect policy.

c) Were issues of Sammy's transgender, equality, diversity and inclusion considered when working with Sammy?

9.3.17 – Sammy told professionals that she did not like to speak on the telephone to communicate her needs, risks and circumstances. She was more comfortable talking to people in person, especially when communicating her needs.

9.3.18 – This option was not afforded to her when she needed support for her mental health and suicide ideation.

9.3.19 – There was an expectation that Sammy would contact services by telephone, and she was not able to do this effectively. This is learning for agencies in understanding and responding to communication needs that have been requested by adults in need.

9.3.20 – Professionals identified areas of need that Sammy presented with by some communication with her to provide her with practical support. However, this was not then complemented with additional multi agency scaffolding and support for her. For example, she was offered transport to take her to appointments, it had not been considered that she would not attend appointments if she did not have someone to care for her dog.

9.3.21 – The question of mental capacity also comes from Sammy's suicide ideation and self-neglect. Were opportunities missed on specific times in working with Sammy for a mental capacity assessment? It could be argued that an assessment may have been helpful especially in clarifying her understanding of the impact of not accessing mental and physical health support at times of crisis and how it might affect her health.

9.3.22 – Further communication between agencies about what was known about herself neglect and suicide ideation could have led to an assessment under the Mental Health Act. An assessment would have provided all agencies with further information about Sammy's mental

capacity to care for herself, especially during the difficult and isolating covid period. In the period covered by this review, there is no evidence that a Mental Health Act assessment was needed for Sammy. It was assumed that she had capacity.

d) What is the significance of this finding to the functioning of the safeguarding system?

9.3.23 – There is a need for a multi-agency pathway for crisis situations as a significant finding for the wider system. For example, when Sammy told officers that she was going to take her own life imminently.

9.3.24 – A group met to discuss how multi agency processes work to safeguard adults at risk. From this discussion, it is evident that there is a gap in the provision for crisis situations where front line staff (in this case from St Leger Homes and SYFR are left wondering whether to stay or leave a vulnerable adult who has told them they are going to take their own life after they leave.

9.3.25 – When they contacted the crisis team, they were asked to contact emergency 999 service and when they contacted 999, they were asked to contact crisis team. The implementation of Right Person Right Care for South Yorkshire Police aims to ensure that incidents such as reported by Sammy are dealt with by the correct team could offer the required support needed. These changes have come into effect after the sad death of Sammy.

9.3.26 – However, in the heat of a crisis for an adult at-risk, front-line staff are left with the person without immediate support. This is an area of practice that the partnership will want to review and consider making changes. A pathway agreed by the partnership is needed. The Integrated Care Board has commissioned the Crisis Team for specific service level agreement.

9.3.27 – A protocol may be needed to provide clarity to front line staff when faced with complex situations and to ensure sufficient support is provided for the level of risk they are attempting to manage.

9.4. Finding 4. - The effectiveness of communications with the adult at risk and professionals was effective given previous safeguarding concerns.

a) How did the finding manifest in the case?

9.4.1 – In January 2021, when the Wellbeing team went to visit Sammy, she was reported to have difficulties communicating and presented as

‘difficult to converse with’. It is not clear from the records what this means, but it could be that Sammy was experiencing mental health difficulties at the time.

9.4.2 – Effective multi agency working requires good communication between agencies but is predicated on communication with the adult at risk. There were a few front-line officers who were able to communicate with Sammy therefore identifying her needs and sharing these with other agencies.

9.4.3 – Significantly there was good engagement bar her GP and therapy services. Sammy did not take up offers of therapies, this could be viewed as another issue in her self-neglect.

9.4.4 – Sammy was discharged into the care of the GP, as an adult with mental capacity, she was expected to contact the GP and when she did not, there was no onus on the GP to contact her.

9.4.5 – It is not known whether the GP did contact her, but good practice would suggest that there is some contact from the GP to pursue an appointment with her, given the history of severe self-neglect and suicide ideation that was known by agencies.

9.4.6 – This is likely to have exacerbated her symptoms and presentation of poor mental health and suicide ideation. Current multi agency processes expect that vulnerable adults will find and source services that they require and need. This was not always the case for Sammy. While processes and services may be available vulnerable adults may require additional support to access services.

9.4.7 – In addition, the 6 principles of Making Safeguarding Personal (empowerment, proportionality, accountability, partnership, prevention and protection) should have applied to Sammy in this decision. Sammy’s engagement with her GP was minimal. She was recorded as having GP surgeries involved with her, and her diagnosis of mental health needs were recorded by her GP. However, it would be reasonable to expect some professional curiosity and follow through about why she had not accessed GP services and hospital services when she needed them.

9.4.8 – Given her range of vulnerabilities and communication needs, one might have expected some follow up especially around medication management and suicide ideation. There was contact with Sammy by many agencies, at times information was shared and referrals made.

9.4.9 – However, communication with Sammy was limited and work with her could have improved if the communication went further than sharing incidents and information but to communicate with her about how she was feeling, her daily life and challenges. Multi-agency communication which focused on the patterns of her vulnerabilities, discussed the pattern of need and a collective plan to respond to these needs could have been

supportive to her. Sammy had told several different professionals and neighbours that they wanted to take her own life.

b) Were issues of self-neglect, suicide ideation and childhood trauma relevant in this finding?

9.4.10 – Good person-based communication with Sammy was a crucial to provide her with the services, support and therapies she needed. The pattern of self-neglect, suicide ideation and the impact of childhood trauma of abuse was not fully understood by anyone agency.

9.4.11 – There were practical measures taken to provide her with support to manage the impact of self-neglect, which is home conditions, clearing and cleaning her property, making it safe to live in.

9.4.12 – All these activities are important to provide a safe space for her to live in. However, they do not in themselves provide support to address the deeper issues and particularly suicide ideation and childhood trauma.

9.4.13 – Communication with Sammy was in some cases very good, that was with front line staff from the housing officer, high risk coordinator, police officer who worked in the area and her Wellbeing officer.

9.4.14 – These individual officers have come through as key in supporting Sammy in her day-to-day life needs and supporting her with any of her everyday needs and identifying deterioration of Sammy's living conditions when her home was in particularly poor condition.

9.4.15 – The gap in support was more therapeutic services in responding to the more complex needs including any root causes of the issues that she presented with in self-neglect and suicide ideation. Sammy was offered therapy but did not attend the sessions, again the process for support is in place but there may be some further work required within the partnership to support vulnerable adults to access the support.

9.4.16 – Sammy's family have reported that there is learning for the partnership about how they felt about how they were told about Sammy's sad death and support following her death, including having conversations about what happened. There is considerable value in providing support for families at the time of crisis, but equally important is further offer of support to process what happened to their loved one.

c) Were issues of Sammy's transgender, equality, diversity and inclusion considered when working with Sammy?

9.4.17 – None of the agencies working with Sammy were aware of her choice to potentially transition into a different gender to that she was born with. There was some indication of this demonstrated in the work carried

out by some agencies, but this was not considered to be an issue to take further with Sammy.

9.4.18 – For example, to support her with a referral to a relevant agency, have discussions about the impact of this part of her identity on her self-esteem, sense of self all these issues would have impacted on Sammy's mental and physical well-being. Further work may be required to understand how well transgender issues are communicated and worked with when supporting vulnerable adults.

9.4.19 – Sammy's mental health fluctuated and officers attending her home were aware that at times, she was chatty, engaging and at other times officers reported that she was 'agitated and preoccupied.' Mental health as a form of disability requires implementation of responses that are appropriate and communicated well with vulnerable adults. All services have equality, diversity and inclusion services and may need to consider how these are impacting on working with vulnerable adults.

d) What is the significance of this finding to the functioning of the safeguarding system?

9.4.20 – Wider system learning about transgender identity, how individuals may be isolated because of it and what support they may need could be arranged by the DSAB as learning from this review. Sammy's sense of isolation due to her transgender identity is unlikely to have been clearly evidenced in Sammy's communication with professionals who came in touch with her.

9.4.21 – Communication with adults who have been assessed as not 'high risk' but have considerable needs require some specialist communication which goes beyond the presenting issue. For Sammy, there were professionals with whom she had regular contact.

9.4.22 – However, she also needed some specialist support which would have demonstrated communication at a level that would have met her needs, risks and circumstances.

9.4.23 – Multi-agency process and communication between individual agencies and professionals was found to be variable. There was very good communication when Sammy's home conditions deteriorated, and she needed support to clear and clean her home and when she maintained cleaning after the intervention.

9.4.24 – There is less evidence of effective multi agency working on the less practical and more complex needs relating to suicide ideation, self-harm and mental health needs. There are incidents when agencies have communicated well, but this was not consistently the case.

9.5. Finding 5. - Explore involvement of agencies pre-18 and what support was accessed by Sammy. What

impact if any did Sammy 's childhood have on presenting concerns in adulthood

a) How did the finding manifest in the case?

9.5.1 – While there are details set out in Sammy's chronologies about what happened to her when she was a child. There was very little information about the involvement of agencies when she was under 18 years old. It was agreed by the panel that to review Sammy's circumstances as an adult. The records held by adult services about her childhood would be used to consider her childhood experiences and the impact of these on her as an adult.

9.5.2 – What is known is that there was likely to have been trauma in her early life as she had reported that she was a victim of sexual abuse perpetrated by her brother. In a meeting with her family, they reported that on reflection that they understand that because of living arrangements, partly due to the intervention of children's social care to safeguard Sammy from abuse, she may have felt that she had been separated from her family and her brother was rewarded by getting a flat.

9.5.3 – The family members have been open and honest about issues that may have impacted from Sammy's childhood to her vulnerabilities as an adult. This has been very welcomed, and the reviewer is grateful to all family members who engaged in completion of this review.

9.5.4 – Sammy's childhood and family background was not known in detail by agencies and the narrative of her childhood was received from adult records and family members. From the information held by services, it was known that she had reported that she did not have much contact with her family as an adult.

9.5.5– However, her family have reported that this was not the case but could understand why Sammy would feel that there was a distance. Sammy lived near her family and visited her parents garden often during covid.

9.5.6 – Her family supported her and spent money to refurbish her bungalow when she was at risk of eviction because of the condition it was kept in. There is little known about the support that Sammy received from her family by the wider multi agency partnership officers who worked with her.

9.5.7 – During COVID, Sammy's mother was very ill and sadly later passed, she was not part of 'a bubble' which the government had implemented to stop the spread of the disease especially amongst those who had illnesses and particular conditions. There was some contact between the two sisters which indicated there was a good relationship.

9.5.8 – Although childhood trauma has its limits in assessing the impact on adult life of the 10 identified as 'adverse' conditions. It provides a framework to understand and consider childhood difficulties and how they may have implications for what happens to an adult. In preparing this review, the information about Sammy's childhood was considered from the lens of what happened to her as an adult.

9.5.9 – The impact of childhood trauma has been researched [19]. Adverse childhood experiences can morph into adult trauma and impact on experiences in adult life. The indicators of this trauma for Sammy are illustrated by her difficult relationship and isolation from her family, especially at the time when her mother had died, and she was not able to attend her funeral, the distress this caused her.

9.5.10 – There are other indicators, for example Sammy being financially exploited by a 'friend' who had taken her bank card, taken out a large sum of money and only gave her a small amount. Difficulties in childhood can also lead to feeling unable and unmotivated to respond to behaviours of exploitation, feelings of being a victim and not feeling able to act of going to the authorities to complain about being exploited.

b) Were issues of self-neglect, suicide ideation and childhood trauma relevant in this finding?

9.5.11 – Childhood trauma has been associated with adult vulnerabilities. Sammy was not always able to communicate on the telephone and this may have been because of childhood trauma, difficulties with communicating her needs because of her mental health needs or other reasons.

9.5.12 – Research has found a link between adult suicide ideation and self-neglect for those adults who have had childhood trauma or experienced abuse.

9.5.13 – Childhood development of a sense of self follows through into adulthood and if there has been childhood trauma or abuse, therapeutic interventions are important.

9.5.14 – Trauma informed practice can be used to approach women who are vulnerable by having a conversation about need and listening to the needs holistically as well as how the woman/transperson present their needs.

9.5.15 – For example, saying that she is fine when she was experiencing difficulties. Childhood trauma can lead to not being able to trust others. Sammy told practitioners that she did not trust people. Sammy found it

[19] Asmussen K; Fischer, F and McBride T - Adverse Childhood Experiences, what we know, what we don't know and what should happen next' Early Intervention Foundation. 2020.

difficult to navigate services and to articulate her needs in the way that services are designed.

c) Were issues of Sammy's transgender, equality, diversity and inclusion considered when working with Sammy?

9.5.16 – It is not known how long Sammy had struggled with her gender identity prior to the action she took several years before her sad death. The most detailed understanding of her gender identity issues was understood for this review from her family. They told the reviewer and professionals in Doncaster that Sammy had changed her name, her clothing and presentation to look more like the gender that she wished to trans towards and that was male.

9.5.17 – There is little information about how this will have impacted her in her childhood and most likely to have been an additional issue that caused trauma and difficulties in relating to others, social interaction and sense of self. The wider issues about diversity and inclusion have been addressed by many agencies. The issue of gender identity was not specifically addressed in working with Sammy. There is clear learning here for the partnership to provide additional training and support.

9.5.18 – Transgender in the Independent Management Reviews or during discussions with professionals, was an area of need that was potentially invisible. The link back to Sammy's childhood about her gender identity may have provided professionals with information and understanding about some of her needs. This issue requires further exploration and as with other issues in this review, there is little known link between her adult vulnerabilities and childhood needs, risks and circumstances.

9.5.19 – Prior to meeting with the family, the information available to the reviewer indicated that there was a fractured or 'complex' relationship between Sammy and her family. After discussions with the family members who have contributed to this review, further light was shed to this issue.

9.5.20 – They have explained their relationship with Sammy, the distance over Covid due to Sammy's mother's illness and the need to keep her father safe because older people were more vulnerable to Covid. Sammy's parents' home was a safe space for her, and she gravitated to her parent's home when she was in difficulty. Her parent's home is walking distances from her home.

9.5.21 – Family members have shared their journey of contact with agencies, their belief that Sammy did not die by suicide but there were other circumstances that involved adults whom Sammy knew prior to her sad death who may have posed a risk to her.

9.5.22 – The family have also requested to DSAB to review and consider how families are told about the death of a loved one. The complaint raised

by the family was referred to the Professional Standards Department and it was concluded that the professional delivering the news acted appropriately.

9.5.23 – However, further work could be undertaken as learning for the partnership about how to support families by providing support when the death is communicated and an offer of on-going support.

d) What is the significance of this finding to the functioning of the safeguarding system?

9.5.24 – The current system of transition between adult and children's services is usually based on a young person becoming a care experienced young person and therefore receiving relevant services. Sammy would not have received that transition service because she was living with her family at the time of becoming an adult.

9.5.25 – A further question is whether if Sammy had been open to adult social care because of her vulnerabilities, could more have been known about her childhood trauma and therefore referrals to be made to more specialist services that provide her with support to understand childhood trauma informed work.

9.5.26 – It would be useful for professionals to have a greater understanding of what happens to an adult known to have experienced trauma when they were a child. The gathering of history, being inquisitive about what happened to an adult and challenging perceptions is key learning from this review.

9.5.27 – The wider system in DSAB partnership may want to consider what processes need to be in place to progress with this, especially if the adult has been in the care of the Local Authority.

10. Recommendations

10.1 – The approaches to services and self-challenge are positive. However, further work is required to work through and weave in processes for multi-agency working together, sharing information, risk assessments, interventions and follow up when risks have been identified by one agency.

10.2 – Professionals working with Sammy have been reflective about their practice and have contributed well to this review. Adult Social Care has reviewed its approaches to referrals when they come in from agencies. There is work under way in developing understanding of work with suicide ideation.

10.3 – Where appropriate, agencies have also highlighted areas of learning for their own organisations, and this is positive. The DSAB will want to ensure that this learning is drawn together and implemented.

10.4 – This could be tested by carrying out multi agency reviews of the impact of this work on vulnerable adults, particularly women. The DSAB will want to consider the impact of changes to practice and to provide overall leadership for change for vulnerable adults like Sammy.

Recommendation 1	**The DSAB Self Neglect Group to seek assurance and evidence of practice either through multi agency audit, training, workshops or other methods about how self-neglect cases with where suicide ideation or suicide and issues relating to inequality, diversity is a feature.**
Recommendation 2	**The DSAB seeks assurance that protected characteristics are recognised, recorded and are included in work with vulnerable adults. This should include professional curiosity about how LGBTQ and adult vulnerabilities intersect with each other.**
Recommendation 3	**The DSAB reviews multi agency processes in place to respond to the needs of adults who 'do not attend' medical and health appointments.** **The DSAB to devise a policy which includes multi agency action plan to meet the needs of adults who 'do not attend' meetings. This should include a review of the impact of ICB commissioned Crisis Team for adults at risk. The ICB should review and suggest guidance for G. P's when vulnerable adults do not attend appointments.**
Recommendation 4	**The DSAB devises (or revises if in place) guidance for the multi-agency partnership to raise escalations or professional challenge when appropriate responses for vulnerable adults are not in place.**
Recommendation 5	**Consideration to be given to an adult / all age trauma informed exploitation strategy that draws on the links between childhood trauma and impacts on adulthood.** **The DSAB will want to be assured that agencies can take a more trauma informed approach when working with adults.** **Agencies explore the impact of childhood trauma on vulnerable adults and what multi agency processes are there to cascade and share information about childhood trauma, adverse childhood experiences with adult services to provide a more effective referral, assessment and planning processes.**

Recommendation 6	**A protocol for front line staff when faced with difficult crisis. The DSAB will want to be assured that front line staff are supported by the partnership when faced with crisis situations.**
Recommendation 7	**DSAB to review and implement good practice guidance to involve families at an early stage when a decision is made to conduct Safeguarding Adults. Family and/or friends to be identified at an early stage in the SAR process. Best methods to communicate with families are sought for them to engage in the SAR and to share their views.**