Sheffield Safeguarding Adult Partnership

HARRIS
(Assigned pseudonym)

A Safeguarding Adults Review (SAR)

V6 FINAL POST BOARD

Author: Karen Rees

Presented to Sheffield Adult Safeguarding Partnership (SASP) 1 April 2022

This report is strictly confidential and must not be disclosed to third parties without discussion and agreement with the SASP
The disclosure of information (beyond that which is agreed) will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

CONTENTS

1 INTRODUCTION 3

2 PROCESS AND SCOPE 3

3 FAMILY INVOLVEMENT IN THE REVIEW 3

4 BACKGROUND PRIOR TO SCOPING PERIOD 3

5 ISSUES FACING HARRIS DURING THE REVIEW PERIOD 4

6 ANALYSIS AND LEARNING 7

7 SUMMARY and CONCLUSION 17

8 RECOMMENDATIONS 19

Appendix One: Terms of Reference (redacted for publication) 21

1. INTRODUCTION

1.1. Information known at the beginning of the review was that Harris was a gentleman of British Asian origin who was 49 years old at the time that he was found deceased at his home. Initially there were concerns that his death may have been suspicious due to implements that could have been weapons being found close to Harris. As there was no sign of any forced entry this was ruled out. Harris was known to a range of local services due to his mental health needs, his drug use and needs from a reported head injury he received as a child. Some of those services had discharged Harris in the year before his death. Harris was married but difficulties in the relationship and alleged domestic abuse from Harris towards his wife led to a breakdown in the relationship. Harris spent a period of time homeless in the year before his death. The coroner recorded a verdict of drug related death from opiate toxicity.

2. PROCESS AND SCOPE AND REVIEWER FOR THE SAR

2.1. The Terms of Reference, scope and methodology for the SAR can be found in Appendix 1. The review set out to cover a 17-month period prior to the death of Harris. SASP commissioned an independent reviewer to chair and author this SAR[1].

3. FAMILY INVOLVEMNT IN THE REVIEW

3.1. A key part of undertaking a SAR is to ensure that families are integral to the review process. Families can provide their views and insights that professionals may not have. A more complete picture of the person is often available from families who often provide a unique perspective. SASP wrote to Harris's wife to inform her of the review. Sensitivities around birthday and anniversary of death necessitated an initial delay in contact by the author. Harris's wife agreed to be involved and spoke with the author via video call. Her thoughts and views are included at points where they support learning. Harris's wife did not believe that other members of the family would have had information related to services received, but that she would feedback learning to them. The Author updated Harris's wife periodically on the process of the review and with the Board manager met with Harris's wife following completion of the report to feedback the learning. Arrangements were made for the family to receive a copy of the report following Board sign off.

4. BACKGROUND PRIOR TO SCOPING PERIOD

4.1. Harris described himself as British Asian, having been born in the United Kingdom. Professionals informed the review that there were no language or cultural issues that required adjustments to be made in the way that assessments were undertaken, or care was delivered. Harris had a white British wife with whom he had been in a relationship with for 18 years and two children from that relationship. Harris also had a stepson who he had brought up as his own son from a very young age.

---

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

4.2. Harris was described by professionals that met him, to be an articulate and intelligent man, who could be quite witty. Harris's wife confirmed to the author that he was very charismatic and funny albeit he could be loud and speak over people which others found difficult to manage. Harris's mental health difficulties could make him come across to other people as agitated and aggressive. He was described as not being able to sit during consultations and had a high level of paranoia, particularly regarding technical equipment within the home.

4.3. Mental health and social care services appeared, from reports, to have first had contact with Harris six years prior to the review period. This had been due to reports of several head injuries he stated had been received as a child and in later years. The GP had referred Harris to the brain injury team (part of the Long-Term Neurological Conditions service, LTNC) in the Mental Health NHS Trust as Harris and his wife were concerned about how he was managing day to day functioning because of the suspected brain injuries.

4.4. Harris was assessed by Adult Social Care as having eligible care needs because of his brain injuries and was supported by a direct payment budget. This enabled Harris to pay for two personal assistants. The number of funded hours changed in the six years prior to the review period, but at each review Harris met eligible criteria for support.

4.5. Harris underwent an MRI scan of his brain and was not found to have a brain injury of any clinical significance and not of the severity that would have caused the symptoms that Harris was displaying. Nevertheless, Harris was placed on the minor head injury pathway and had support from a specialist neuro case management service within LTNC. This had originally been commissioned as a lifelong service but due to service provision changes, it adjusted to providing shorter-term & episodic interventions rather than a continuous lifelong service.

4.6. In the period just prior to the review timescale, Harris's case management was transferred from social care to mental health services as it was deemed that his needs attributed to longer-term mental health difficulties and would be better met by the teams that had expertise in mental health needs.

4.7. Harris was also known to misuse substances; this had been listed in GP records as a problem since his mid-thirties. Harris's wife came to learn that his behaviour and arguments in their relationship were always much worse when Harris was taking drugs. His wife told the author that he had periods of being drug free but that he had made friends with a man who was a drug user, and this led to Harris 'dabbling' in more drugs over the last 3-4 years. Harris also suffered from mental health disorders of anxiety and paranoia and was undergoing a period of assessment with the Mental Health NHS Trust's Early Intervention Service in the period prior to the review.

5. ISSUES FACING HARRIS DURING THE REVIEW PERIOD

5.1. This section will briefly describe the issues facing Harris during the 17-month period of the review as presented in the reports and additional information gathered from agencies who worked with him. Section six will analyse in more detail the interactions and multiagency working regarding these issues.

Mental Health

5.2. Harris was assessed by the Early Intervention Service (EIS) and was subsequently diagnosed with Emotionally Unstable Personality Disorder (EUPD)[2]. Harris was also referred for assessment of autism. Harris explained to other services that he met with that he was suffering from brain injuries and mental health issues.

5.3. As a result of Harris's diagnosis, the Early Intervention Service discharged Harris from their service as he did not have a psychotic illness. He was referred to the recovery service who support people with a range of ongoing or complex mental health needs including EUPD. This happened two months into the review period.

5.4. The recovery service did not feel that Harris would benefit from receiving a service from them and he was discharged back to the care of his GP. This will be explored in section six.

5.5. Harris had been referred back to Adult Social Care by mental health services for assessment and case management as it was deemed that his needs related to social care needs rather than mental health needs. There were disagreements regarding whether adult social care or mental health services should take the lead role. Ultimately Harris was reassessed by adult social care in the second month of the review period and was then deemed not eligible for social care support and funding. Harris had no further support from personal assistants following that assessment. His wife and family took up the supporting role.

5.6. Harris was presenting regularly to the Mental Health NHS Trust Single Point of Access (SPA); contacts were also made by other services with concerns for Harris. Harris was allocated to the Emotional Well-Being Service (EWS)[3] of the Mental Health NHS Trust four months after he was discharged from EIS. This support was limited as the worker struggled to engage with Harris and he was only seen twice. Harris was subsequently discharged in the months before he died. Harris had sporadic contact with the NHS Mental Health NHS Trust drugs services regarding nondrugs related difficulties. Harris was not open to these services but had knowledge of them from previous referrals.

5.7. Harris presented to the Emergency Department on three occasions in the year before he died with suicidal thoughts. On the last occasion, nine months before he died, he had taken an overdose and was admitted to hospital for observations overnight.

---

[2] **Emotionally unstable personality disorder** (**EUPD**) also known as **borderline personality disorder** (**BPD)** is a personality disorder characterised by a long-term pattern of unstable interpersonal relationships, distorted sense of self, and strong emotional reactions. Those affected often engage in self-harm and other dangerous behaviours, often due to their difficulty with returning their emotional level to a healthy or normal baseline. They may also struggle with a feeling of emptiness, fear of abandonment, and detachment from reality. Symptoms of BPD may be triggered by events considered normal to others. BPD typically begins by early adulthood and occurs across a variety of situations. Substance use disorders, depression, and eating disorders are commonly associated with BPD. Approximately 10% of people affected with the disorder die by suicide. https://en.wikipedia.org/wiki/Borderline_personality_disorder - cite_note-16 (Taken from Wikipedia- Information independently checked for accuracy).

[3] The Emotional Wellbeing Service provides a bridge between primary and secondary mental health services

5.8. Towards the end of the review period Harris began to be assessed by the Autism Team in the Mental Health NHS Trust. The assessment was incomplete when Harris died. This was because Harris did not want to have the assessment done via video call (as a result of the covid pandemic restrictions) and then non-attendance by Harris.

Associated Issues

5.9. Harris was known to other services during the review period due to the impact that his EUPD had on his relationships and social awareness skills. At the time, those other services were not aware that it was Harris's EUPD that was linked to the way he presented. His symptoms of not being able to manage relationships either professional or family, his agitation and aggression in times of stress led to the following issues:

- missing important appointments
- continued substance misuse
- self-harm (suicide threats and attempts)
- perpetrator of domestic abuse; impact on family
- homelessness and debts mounting
- paranoia leading to conflicts with neighbours and services
- arrests due to threats and behaviour towards others

5.10. Harris's complex and difficult needs made him present as demanding of services with some professionals finding it difficult to cope with these.

5.11. As a result of the above listed difficulties and no longer having the support of personal assistants, Harris sought the support of an independent advocate from a charitable organisation that provides various advocacy services within the area. Harris was eligible for Care Act advocacy under the NHS Complaints and Generic Mental Health advocacy remits. He had an advocate allocated in month four of the review period. This was an instructed advocate. Where a person retains mental capacity (discussed later) as in this case, the advocate can only act on behalf of the person based on what the person is requesting and cannot act independently of the person they represent.

5.12. Harris was also supported by the local authority housing department that manages and supports people to prevent or rehouse homeless people. Harris spent a period of time being supported in a hostel for the homeless provided by a registered church and charity. Harris was referred to substance misuse services at this time but they were unable to engage him.

5.13. Harris had regular contact with his GP who knew him well. Towards the middle and end of the review period, Harris was requesting more medication at a rate above his prescribed amount. Harris refused to agree to have his medication reviewed or reduced.

5.14. Harris came to the attention of police on many occasions within the review period, some of that was due to reports of domestic abuse, concerns that his computer and phone and those of his family had been hacked. Harris's calls to police regarding the hacking that he stated he was experiencing were excessive. The calls from Harris's wife related to domestic abuse were associated Harris's paranoia and

lengthy heated arguments that were impacting on her and the children. Harris's wife told the author that Harris could argue over one point for hours and hours at a time. At the time, Harris's wife was also caring for her mother who had dementia and a child who had special needs. Harris's patterns of behaviour were causing extra difficulties. Harris was also arrested on a few occasions after being involved in conflicts with other residents and staff at the hostel when he was homeless.

6. ANALYSIS AND LEARNING

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

Mental Health /Social Care Interface

6.2. Harris was assessed by the various services that he encountered, both statutory and third sector, using recognised assessment tools in place within those services. The overall impression was one of caring services who wanted to provide the best care they could, based on the information available to them at the time.

6.3. For Mental Health NHS Trust services, including brain injury services, the conclusions of assessments were in line with protocols, and exceeded the requirement that was offered up to the point at which EIS discharged Harris. LTNC Brain Injury services had continued to follow up Harris despite the MRI scan showing that any minor head injury would have little clinical impact on his presentation at that time. Harris was discharged from the Brain Injury service in the second month of the review period. It appears that maintaining brain injury services gave the impression to Harris, his family and other professionals, that he did have a brain injury requiring service provision.

6.4. The decision that Harris would not benefit from being accepted into secondary mental health recovery services was because it was assessed, from past and recent history, that Harris would not be able to engage in building a therapeutic relationship and achieve mental health stability through therapy. Harris was offered and initially attended a Short-Term Educational Programme for people with EUPD to help create insight and self-management skills. Harris was not able to manage attending a group and would have needed direct work in the first instance. As discussed previously Harris was very hard to engage and struggled to focus on what professionals were trying to achieve with him.

6.5. Harris's wife told the author that there was evidence that Harris could develop good relationships with professionals and that he had attended many appointments with support. Harris's wife related the story of the relationship that Harris had built up with a member of the community brain injury team that led to his disclosure of abuse in his childhood. Previously, Harris also had very good relationship with his social worker. Harris's wife felt that it was unfair that he could not be offered therapeutic support for his EUPD based on assumption that he would not benefit; she did agree that group work

was not appropriate for Harris.

6.6. At that time, mental health professionals felt that there was little more that could be done to support Harris within those services, so he was discharged back to the care of the GP.

6.7. The EWS service had continued to try to offer support for Harris and was used as a bridging service. This service, however, is time limited and not intended for long term support. This service did keep Harris on their caseload well over the usual allotted timescale.

6.8. Whilst on the surface these decisions were made in line with assessment outcomes, it seems that they were made without full understanding of the issues that were being presented to other organisations.

6.9. The professionals meeting to agree Harris's discharge that was undertaken with Harris's advocate present, did not have any other organisations represented. The GP had been asked by Harris to attend but was unable to do so but had offered information for the meeting. Having said that, there were very few professionals involved at the time of the discharge from EIS; Police however were still in regular contact with Harris and dealing with the impact of his EUPD. Police believed that Harris had a brain injury and mental health issues but were not aware of the diagnosis of EUPD and that the brain injury was in fact insignificant and not the cause of his presentations.

6.10. It does not appear that Mental Health Services were able to take into account that Harris would not be getting any support from Adult Social Care. Harris made a complaint regarding his discharge from mental health services as he felt he still needed support.

6.11. Research and evidence of what works when working with EUPD would suggest that the building of a therapeutic relationship may be hard and take time but that it is the underpinning principle to be able to work successfully with those with EUPD[4]. Very recent guidance[5] has indicated that a tiered pathway should be developed that identifies the needs of the person and the services and strategies that will best support a person. It is noted that there may be other services involved and that for those with complex needs, having an allocated care coordinator can bring professionals from other agencies together to formulate an assessment of needs that is wider than just from the knowledge of mental health services. The Mental Health NHS Trust in the locality does not have a formalised pathway of this nature.

> *"Pathways must operate within a system of close administrative and clinical cooperation. This includes the availability of upwards referral when somebody is not engaged or deteriorating or causing dynamic problems within a group or service, indicating a need for greater intensity of intervention. Failure to engage or respond to treatment efforts should prompt the service to respond creatively and with a greater emphasis on developing a milieu which supports engagement."*
>
> Royal College of Psychiatrists PS01/20 Position Statement p.20

[4] NHS Highland Personality Disorder Integrated Care Pathway (PD–ICP) November 2015 https://www.nhshighland.scot.nhs.uk/services/pages/personalitydisorderservice.aspx

[5] Royal College Of Psychiatrists PS01/20 Position Statement; Services for people diagnosable with personality disorder January, 2020 https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2

6.12. The reason that there were no appropriate services for Harris was because currently in the locality, Primary and Secondary Mental Health services are not commissioned to offer services where people cannot be engaged with. If services are unable to engage with a person for whatever reason, as in the case of Harris, then this will lead to discharge back to GP. There is a regional Pathway Development Service for those with complex personality disorders that would sit at tier three of the suggested tiered pathway which is a level above the tier two service offered locally. Harris was not considered to meet the level of complexity to refer to this service. Had all information known to every service been known and understood by mental health services prior to discharge then the decision may have been different.

6.13. Mental Health services believed that Harris should be eligible for Adult Social Care services and that he would get support in that way. Mental health services identified that it was practical help that Harris would benefit from to help him manage his day-to-day functioning.

6.14. The assessment undertaken by Adult Social Care that deemed him ineligible for care and support, has been thoroughly analysed in the agency report for the review and recommendations have been made. The reason that Harris was assessed as not having eligible needs under the Care Act, was because the report from the mental health team clearly stated that there was no brain injury that would be causing difficulties. It has been identified within this review, that the needs of Harris had not changed just the diagnosis. These needs were not identified within the assessment.

6.15. There was some excellent challenge from the advocate and the GP to this decision; the second look decision in Adult Social Care did not change the outcome and those who had challenged, reluctantly accepted the decision.

6.16. At this point, without the day-to-day support, Harris was coming to the attention of SPA services in the Mental Health NHS trust as his EUPD presentations were having a direct impact on his interactions with others. With no long-term structured programme or support from services Harris struggled to manage his life, leading to homelessness, arrests, increase in use of illegal substances and constant requests for more medication from his GP to calm him and manage his feelings.

6.17. The author would suggest that for a person like Harris, having needs of both a social care and mental health nature required both services to have some involvement or at least agree which service was a best fit based on all information known and knowable. There were several opportunities missed for a robust handover between the two services. The review has identified that there are no transfer protocol arrangements in place between the two services who are often in the situation of transferring people between them. Without this in place, there are difficulties in understanding what should happen at the point of suggested transfer and nothing in place with which to challenge by if there are disagreements between the services. A written agreed protocol which covers the above is needed to strengthen the system.

6.18. Those organisations who were supporting Harris outside of the statutory services did not feel able to navigate the systems to challenge the need for more formal longer-term involvement from a specialist mental health team that best practice would suggest.

6.19. Without a social worker or a mental health care coordinator, there was no coordination of care across all agencies; this will be picked up in a later section.

Points for strengthening practice:

- When working with people mental health and social care needs it is useful to ensure that communication pathways are clear for both services and other professionals.
- Assessments that take account of all available information from several sources are likely to meet the needs of a person more effectively.
- Those people with EUPD, being a complex and common disorder, benefit from availability of defined pathways of care that allow for time and space to build relationships.
- Self-management is an evidence-based goal for EUPD; many people will need significant support to get to that point and may always need day to day support.

Domestic Abuse and Safeguarding

6.20. Harris's symptoms of EUPD, his intense paranoia at times and his difficulties in managing relationships led to the domestic abuse incidents identified previously. On most occasions when police were called Harris's wife did not want to proceed with charges or have information shared with other agencies and this was honoured as she was not assessed as at high risk of harm. Mostly the outcome was that either things were significantly calmer when police arrived, or police asked Harris to leave or arrested and removed him until things settled. Harris was not charged with any offences.

6.21. The analysis of these interventions by police indicate that the Domestic Abuse Stalking and Harassment (DASH) risk assessments were completed well. The information that was shared by Harris's wife indicated increased risk to Harris because of his deteriorating mental health and increasing presentations as a result of his EUPD. The police should have completed more vulnerable adult forms and shared these with Adult Social Care. The one that was completed was closed by Adult Social Care as it was assessed as not meeting the threshold for safeguarding (Section 42 Care Act) and was not referred for a Section 9 Care Act (care and support) assessment, or elsewhere for support. This would have been a way to ensure that although Harris's wife's information was not shared, there was clarity that she was trying to get help and support for Harris. Harris's wife confirmed to the author that she was desperate to get help for him. There were other safeguarding referrals made in the review period from other agencies all concerned about Harris's paranoia with regard to the hacking of his equipment. These referrals were closed because the view was that the issues were imaginary or, if real, a police matter.

6.22. The issues here appear to be twofold. In the first instance, by not applying professional curiosity to the impact that such paranoia may have and the other issues that were causing distress to him and his family, a person-centred approach was not evident and therefore the Making Safeguarding Personal principals[6] were not followed.

[6] **The Making Safeguarding Personal (MSP)** initiative began as far back as 2009 by the Local Government Association and Association of Directors of Adult Social Services to ensure outcome focussed, person centred responses to adult safeguarding, rather than it being a process that happened to people without knowledge. This has since become enshrined in the Care Act (2014) and requires that the adult and /or their representative is part of the safeguarding process.

6.23. Secondly, by not gathering further information from other agencies e.g., Mental Health, GP, it was not possible to see a wider picture. To professionals, the paranoia and level of calls to the police and other agencies may have been due to 'imaginary' situations, but to Harris they were real and taking over his ability to manage his life. Harris's paranoia regarding hacking of his electronic equipment came from the firm belief he had of a hacking incident. Harris stated that the perpetrator had admitted to Harris what he had done. The police investigation found no evidence that there had been a hacking incident. Harris's wife stated that he could be very convincing to the point where she had not known what to believe. Ultimately, she did not believe that there was a real hacking incident. For Harris, however, this was very real and if this had happened once then there was every reason to suspect that it continued to happen and led to his paranoia regarding this issue.

6.24. Harris's inability to see the impact his behaviour had on others brought him into conflict with others when he was homeless.

6.25. Professional curiosity is a label applied that requires understanding so that the term is not used randomly without explanation and that the barriers to its application are understood. Research in 2019[7] drew together information from Safeguarding Adult Reviews and other available literature to review use of professional curiosity in safeguarding adult work. Being professionally curious is about applying imagination and seeking out more information by use of careful questions that may give more information than that which is initially presented. Blocks and barriers to being more curious are noted when each incident is seen in isolation and therefore the cumulative risk is not understood. Reports from Harris's wife that his substance misuse was escalating and the GP knowledge that he was seeking out more medication than was required were not explored further. This information was knowable across the agencies that were working with Harris.

6.26. Another barrier to application of professional curiosity may be the normalisation of EUPD and its impacts. A considerable number of people who present with mental health issues and illness both in primary and secondary care mental health services will have some form of personality disorder. This may mean that the behaviours that are presented are seen as 'normal' for the person and the level of risk is therefore not apparent. In the case of Harris, it was also noted that he would not attend therapy sessions and would be disruptive in groups. Harris's continued behaviour of non-attendance at appointments and not being contactable was therefore seen as 'confirmation' that it was right that he would be hard to engage. This 'confirmation bias' can prevent services from being curious as to what might help to safeguard the person in the future using a wider safeguarding lens.

6.27. There were two safeguarding referrals made in respect of the children due to the domestic abuse that they were experiencing (from the intense arguments and conflict at home) and on one occasion a referral was made by the hospital following Harris's overdose. The EIS team also made a referral. The children's safeguarding procedures were followed, and a Children's Multi-Agency Safeguarding Hub (MASH)[8] discussion resulted in further information being gathered from other services in order to

---

[7] Thacker, H. Anka, A. & Penhale, B. (2019) Could curiosity save lives? An exploration into the value of employing professional curiosity and partnership work in safeguarding adults under the Care Act 2014. **The Journal of Adult Protection** j VOL. 21 NO. 5 2019, pp. 252-267, © Emerald Publishing Limited, ISSN 1466-8203

[8] Multi-agency safeguarding hubs are structures designed to facilitate information-sharing and decision-making on a multi-agency basis often, though not always, through co-locating staff from the local authority, health agencies and the police.

further assess risk of harm to the children. It appears that information was gathered from services in touch with the children but not those working with Harris. When the GP was contacted for any information regarding the family, there was no connection made with some of Harris's difficulties as the GP contacted was the GP for the children; this was not the same GP as for Harris.

6.28. It was also the case that when those working with Harris were recognising the impact on him and those around him of his EUPD he was not seen as a father. Impacts on the children of the intense paranoia, agitation and behaviours that led to police being called, his threats of suicide, substance misuse and his aggressive behaviour towards others were not managed using a whole family approach. Any risks of emotional and physical harm to the children were assessed in isolation. The information received from Children's Social Care for this review indicated that it was felt that appropriate safeguards for the children had been put in place by Harris's wife and adult services. The statistics[5 (IBID)] of the impact on children living with a parent with personality disorder would suggest that it is imperative that children's and adults' services work together to safeguard and support the whole family.

6.29. The Think Family framework[9] was identified as a useful toolkit when working in cases where parental mental health was an issue. This framework recognises that no parent or child exists in isolation and that when an issue affects an adult it has an impact on the child and vice versa.

6.30. Think Family approaches can support all those offering services to each member of the family to think about the services as a whole family intervention. The needs of each individual child, parents as a person with care and support needs and/or as a carer, can be assessed not only from that individual perspective but also as a family unit. This ensures that information regarding service levels and interventions are shared. The model recognises that there may be risks and vulnerabilities in families who have additional needs but also that there are often protective and resilience factors that can be built on.

6.31. There is currently a business case being developed to consider setting up set up an Adult MASH in the area. Where safeguarding referrals are made, early information gathering and sharing across all agencies will make decision making more robust; the professional relationships built by those working within a MASH setting aid multiagency working and collaborative approaches even when a case does not meet the threshold for a Safeguarding Enquiry. Multi agency working outside of safeguarding will be discussed in a later section of this report. An adult MASH alongside a Children's MASH would support a more robust think family approach; the positive impact that this may have cannot be underestimated.

6.32. Harris's Mental Capacity to make decisions was assessed on several occasions. There were no indications that Harris did not have capacity to make decisions; he presented as an adult who had mental capacity and many professionals assumed capacity as per the Mental Capacity Act [10]. It was not

---

https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/collaborative-working-and-partnership/multi-agency-safeguarding-hubs.asp

[9] SCIE 2014 **Think child, think parent, think family: a guide to parental mental health and child welfare** http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

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

apparent that there was any further exploration of executive[11] capacity to carry out actions he had agreed with professionals. Appointments were not attended and engagement and relationships with professionals were not well established. NICE Guidance[12] indicates that professionals need to be aware of executive dysfunction[13] and the difficulty in assessing those people in the usual interview approach. It is by observing the person's ability to function in the real world that may give a complete picture of a person's decision-making capacity. If a person does not display executive capacity, then they would require more support to carry out functions and tasks following apparent capacitous decisions. The use of safeguarding leads and mental capacity experts to support practice can be helpful in these extremely complex situations.

Points for strengthening practice:

- The ability to share information in a safe and secure environment in a timely manner can strengthen the safeguarding system. A MASH provides this strength.
- Think Family is a concept that creates an approach that ensures that a family is seen as a whole, and that risk is assessed, and support given the circumstances within the family.
- Adult and child MASH working together can strengthen the think Family approach.
- Professionals that are supported to have time to work with a curiosity to understand and question situations more deeply can be vital to supporting and strengthening the safeguarding system.
- Understanding of working with people who may have executive capacity dysfunction can lead to improved understanding and follow up with decision making to support the carrying out of agreed actions.

Homelessness

6.33. The response that Harris had from the housing homeless team when he presented as homeless was very good and in line with what The Homelessness Reduction Act[14] was intending. The homeless housing team's good working relationships with providers in the area meant that Harris was quickly found temporary accommodation. The history taking from Harris was extensive and gave a good insight into Harris's needs. The assessment was passed to the hostel workers who set up plans to support Harris to find permanent accommodation and help him with some of his issues such as substance misuse.

6.34. There is some learning here, however. These services took what Harris told them at face value and there was no checking out of the story that Harris presented with. Harris had told the housing homeless team that he was fleeing domestic abuse from his partner. He also said that he had brain injuries that caused cognitive difficulties and that he had suspected bipolar disorder, anxiety and depression. Harris

---

[11] **Executive meaning**: relating to or having the power to put plans or actions into effect.

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

[13] **Executive dysfunction: T**he completion of tasks that involve several steps or decisions normally involves the operation of mental processes known as 'executive functions'. If these executive functions do not develop normally, or are damaged by brain injury or illness, this can cause something called 'executive dysfunction'. This involves a range of difficulties in everyday planning and decision-making, which can be sometimes hard to detect using standard clinical tests and assessments.

[14] Local Government Association. Ministry of Justice (2018) Guidance: **The Homelessness Reduction Act 2017** Duty to Refer. London: The Stationery Office.

stated that he last used illegal substances the previous year. Whilst some of these details were misrepresented by Harris, possibly because he believed that he would have more chance of accommodation by presenting with those issues, he would have been temporarily housed as an emergency based on his mental health issues alone.

6.35. Housing staff have reflected that had they contacted mental health and adult social care services, they may have had a better understanding of Harris's needs and an accurate picture of his diagnosis. The homeless housing team indicated that they have little knowledge of EUPD and how it might affect a person. Contact with mental health services may have alluded to how Harris can present and that may have led to a more accurate needs assessment. Harris did tell the housing homeless team that he should not be placed with others in shared accommodation but not because it was his personality disorder that meant that he would struggle in those situations. The housing homeless team stated that they would have offered more support for appointments with housing providers had they understood Harris more fully.

6.36. Albeit that there was no choice from the emergency temporary accommodation perspective, later offers of shared housing were not ideal. Temporary and more permanent types of housing provision for single men are likely to bring them into contact with other males who have complex life situations. There was some belief amongst professionals and disclosure from Harris that the reason for Harris being more demanding of prescription medication was because some of it had a street value. Being housed in the circumstances that he was, was likely to make him vulnerable to abuse and exploitation. This was not included in consideration when safeguarding referrals were made or by those that were aware of the situation.

6.37. The hostel provider workers were also very sensitive to Harris's needs but were not aware of the EUPD diagnosis and were approaching him as a man with a Brain Injury. They too stated that they had only a little understanding of EUPD and how to approach and structure interventions that would best meet Harris's needs.

6.38. As a result of not being able to be found suitable onward accommodation Harris moved back home but this was not sustained and within a few weeks he was homeless again. He was moved to shared housing but as this was not a sustainable option for him because of his needs; he secured and moved to his own tenancy; it appears that debts were then building, and he stated that he owed rent. Harris's wife stated that his rent was covered by housing benefit and his Disability Living Allowance (more latterly Personal Independence Payment) but did think that debts would be accruing from his increased substance misuse in that period. During the time that Harris was homeless Adult Social Care were not aware of this and no further needs assessment was undertaken; The EWS were trying to offer support to Harris, but they were not able to engage with him and eventually he was discharged from the service.

6.39. Provision of suitable accommodation was not available for Harris in the emergency and temporary accommodation situation. When Harris secured his own accommodation, housing homeless team and hostel support workers were no longer supporting Harris. Harris's life became more unstable and chaotic with no other regular support from agencies in place.

Points for strengthening practice:

- Where a person is known to other services, housing and homeless needs are better understood when information is gathered from those other services.
- Assessment of any gaps in housing provision and support services for those with additional needs may improve ability to apply reasonable adjustments in line with the Equality Act.

Multi Agency Working

6.40. All three areas of analysis above have indicated that a multi-agency approach to Harris that included a Think Family element may have helped services to have a deeper understanding of the needs of Harris and his family. This may have aided robust assessments and service thresholds being met. Each of the services involved offered an assessment and support service based on what they believed at the time. Some services have reflected on their own involvement that service thresholds for provision of a service were met and where that had happened, have made recommendations.

6.41. To aid the fuller picture and strengthen this area, agencies needed a framework to come together and work collaboratively, regularly sharing information to understand life from Harris's perspective.

6.42. The safeguarding enquiries did not lead to a multi-agency conversation to ensure safe decision making. As previously mentioned, this review highlights the need for a MASH or similar system to enable early and facilitated multi agency conversations for decision making. Developing a clear MASH operational guidance would lead to clarity of decision making, feedback to referrers, which organisations may hold information and should be approached, as well as any signposting if a safeguarding enquiry is not the outcome. Through multi organisational cooperation within a single operating procedure and mandate from the Care Act for information sharing, organisations can be assured that information is shared safely and in the interests of both person and public safety (see [15]).

6.43. There are occasions however where a case is either causing difficulties for professionals because of complexity and uncertainty regarding availability of service provision, and/or where a case is discussed in MASH but does not require a safeguarding enquiry under the Care Act. Therefore, there needs to be an alternative system to discuss complex cases where cases of concern can be referred to by professionals or signposted from a MASH discussion. These types of multi-agency system frameworks or 'team around the person' approaches, where they are in place in other areas, have proven to be highly effective ways to bring agencies together to discuss, plan and agree interventions and outcomes based on individual need. In this case it is likely that there would have been better understanding of Harris and his family and improved information sharing.

6.44. It is of note that there is currently a Vulnerable Adult Risk Management Policy and process for complex cases, but that they are more aligned to cases of self-neglect and hoarding or the management of other substantial risks. Part of this policy refers to the use of a complex case management process at tier two where there is no ability or requirement to proceed to a section 42 enquiry. The author would suggest that there needs to be more clarity in the documents, as independently observed, as to the parameters

[15] https://www.lancashire.gov.uk/council/transparency/access-to-information/service-and-project-specific-privacy-notices/mash/

of their use.

6.45. There is also anecdotal evidence that there is a complex case management process being undertaken in some agencies convened when a case is causing concern but is not deemed to be eligible for a safeguarding response. The SASP are currently finalising a process that sits within safeguarding systems that aims to fill the gap and clarify the related operating protocol. This review suggests that, in order to not overcomplicate the system and cause confusion, there needs to be an overall process map to identify how each process relates to the other and what can be used for complex cases that are not self-neglect and/or hoarding.

6.46. Within any system for multiagency working there needs to be a clear escalation protocol to support healthy professional challenge where one agency has a belief that another agency may not have heard or acted on concerns raised. This is vital to the safeguarding of individuals and is highlighted as often lacking in cases. The local protocol has been recently updated that promotes and guides practice in this area. It is often thought that a decision that is made by an agency, whilst frustrating, cannot be challenged. This is not the case and healthy respectful challenge under the agreed protocol is required for robust multiagency working. It is pointed out in literature[16] that practitioners should demonstrate defensible decision making, that being:

- Lawful,
- Reasonable and rational
- Timely
- Mindful of all relevant considerations
- Taken without bias and after consultation with interested parties
- Transparent about whether to exercise available discretion

6.47. In the case of Harris, a robust challenge was made in respect of the assessment and decision by adult social care that Harris no longer had eligible needs. This stopped at the first review instead of being taken further. Of the above list the most noticeable factors were that all relevant considerations were not explored and that interested parties were not always consulted. There must be a clearly understood hierarchy of challenge. All systems for supporting and delivering services must have professional challenge built in order to ensure decision making is defensible with links to complaints processes where appropriate. The reason that, on reflection, decisions may not have been defensible is because there was no effective multi agency team around the person.

6.48. Some organisations involved in this review are trying to promote multiagency working with identifying key access points and preferred time for contacts e.g., the housing homeless team manager has set up specific timeslots that they are available for discussions with probation and likewise the police have set times that the homeless team can call for information.

[16] Michael Preston-Shoot (2020) **Adult safeguarding and homelessness A briefing on positive practice** Local Government Association

6.49. These system improvements have occurred because of the identified need for individual services to enhance their working relationships, communication, and information sharing. These individual system improvements should be applauded and show innovation in trying to bridge the gap in communication systems. What the learning from this review indicates is that this is a requirement of the whole system of care and support services for those with complex needs and presentations.

Points for strengthening practice:

- When individual services work to improve interagency communication, this has a benefit to people with care and support needs.
- Organisations coming together within agreed frameworks for multi-agency working supports professionals to work collaboratively with shared clarity.
- Demonstration of defensible decision making with built in professional challenge provides evidence that practice is in line with organisational and legal requirements.

7. SUMMARY AND CONCLUSION

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

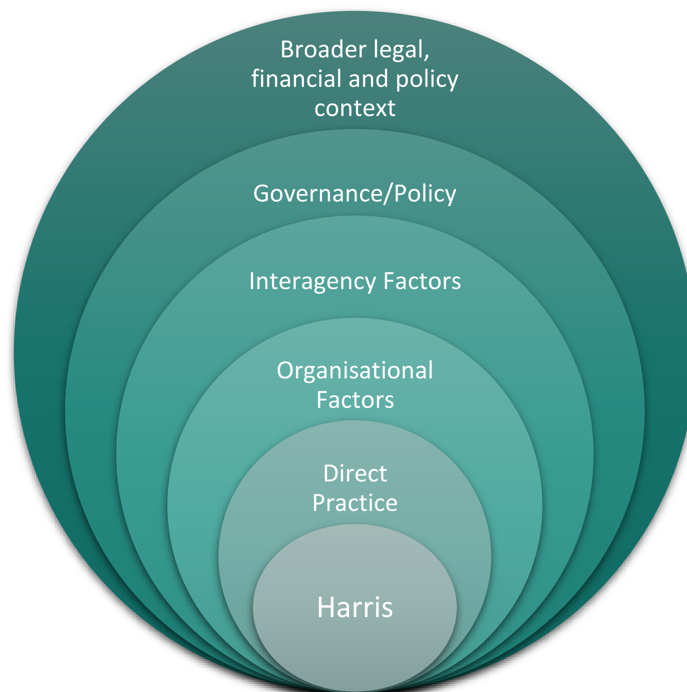

Figure 1. Whole system model from Preston Shoot, M. Shoot (2020) **Adult safeguarding and homelessness A briefing on positive practice** Local Government Association. Pp 8

7.2. Harris is at the centre of the system and relies on the rest of the system to support his and his family's needs. The first domain, direct practice with Harris, came from multiple services. Assessments were of varying quality at this level. Professionals at this level wanted to help Harris and often went over and above service requirements but were struggling with little understanding of full history and needs, not applying professional curiosity, or using a robust 'Think Family' approach. The reason for this was that the second domain was not in place to support direct practice.

7.3. The second domain encompasses the organisational structures around the professionals who were working with Harris. This level provides a framework for professionals to work collaboratively, to share relevant and timely information on receipt of alerts and referrals. Professionals need access to accessible care pathways for people with complex needs and have clear links to contact systems in other organisations. Ensuring that professionals have access to understand EUPD was a feature in this case with staff in several organisations stating that they knew little of how to engage with a person with EUPD. Ensuring support for staff and management oversight of decision making was all in place in part but the lack of multi-agency frameworks of a team around the person approach and a MASH all impeded the interagency work of professionals.

7.4. The interagency domain requires that information and assessment from within organisations is shared where necessary, so that services can work together to provide support to the person. Defensible decision making that is comprehensively recorded is also needed. Some decision making in agencies was very clear with rationale; more is needed to strengthen practice. Again, the requirements here are supported by the next domain.

7.5. The fourth domain is where the Safeguarding Adults Board is positioned. There is work to formulate a MASH, or other similar appropriate collaborative information sharing process, however there are some barriers at the time of writing this report that are being looked at. The Vulnerable Adult Risk Management process and the Complex Case Management process are in use but there needs to be clarity about use and position within the safeguarding system. The importance of this domain ensures that policies and procedures encourage professional challenge and multi-agency working to safeguard adults. The SAB should hold agencies to account where systems require further development or need strengthening.

7.6. In this case the author would suggest that the final domain was also at play to some degree. Nationally there is a need to ensure that housing provision meets the requirements within the Equality Act. Reasonable adjustments need to be able to be made within the accommodation that is commissioned if people with EUPD and complex issues are to be supported effectively and be free from the fear of exploitation. There also needs to be examination of commissioning requirements regarding the system of providing long-term care and support for those with complex personality disorders in secondary mental health services.

7.7. It is the learning within these domains that will lead to recommendations for practice and service strengthening.

8. RECOMMENDATIONS

The recommendations have been built around the noted areas that require consideration for stronger practice. Many of these build on work already ongoing.

1. Mental Health /Social Care Interface

1.1. SASP should identify a Task and Finish group of relevant professionals to develop a Transfer Protocol between Mental Health Trust and Adult Social Care that complements the current dispute resolution process (consideration could be given to making this one document). This should include

- clarity on lead roles
- Information sharing
- challenge and escalation
- when to invoke the dispute resolution process

1.2. SASP should share this SAR with NHSE specialist commissioners. SASP should seek clarity from those commissioners regarding the current and future commissioning arrangements regarding EUPD pathway and ability to work long term in secondary mental health services to build relationships as per best evidence (Royal College of Psychiatrists PS01/20 Position Statement; Services for people diagnosable with personality disorder January 2020) and the learning from this review.

1.3. All relevant agencies should provide SASP with evidence as to how they provide abilities for work in a similar way to trauma informed care approaches when working with those with personality disorder.

2. Domestic Abuse and Safeguarding

2.1. SASP should expedite continuation and finalisation of the consideration of a business model to enhance and improve interagency working and information sharing (that may or may not result in a Multi-Agency Safeguarding Hub). This work must include all relevant partners and consider how the resulting system will link in with the Children's MASH.

2.2. SASP should continue to develop and share the interactive tool for exploration of professional curiosity with partner organisations.

2.3. SAPSP should seek assurance from relevant agencies that professional curiosity is a topic included in all domestic abuse and safeguarding training relevant to the level of training.

2.4. SASP should ask agencies to consider prompts for professional curiosity in assessment documentation.

2.5. SASP should ensure that the work being undertaken within the children's partnership on improving the model for family safeguarding includes agencies that work with adults including adult social care.

2.6. SASP should seek to ensure that single and multi-agency training regarding Mental Capacity Act and refreshers is mandatory for relevant professionals. Training should include what might create

complexities and when and how to seek additional help and support that may include legal advice.

3. Homelessness

3.1. SASP should task Housing and Adult Social Care to seek to establish an automated function between Housing Support Pathway and Liquid Logic so it is easier for staff on each side to see who else is/might be involved with a case.

3.2. Continue with the commissioning for provision of suitable housing for those with complex needs, building on changes that have already been made e.g. the Thrive provision. Ensure that SCC Housing are able to provide accommodation for those with complex needs where no external provision can be found.

4. Multi Agency Working, Communication and Pandemic Impact

4.1. In the remodelling of the VARM policy and process SASP must ensure that the following are addressed:

- Work is proceeded without further delay, with ability to adapt and amend process as it comes into full use
- Clarity of where the process fits in the safeguarding arena and how it may fit with other single agency processes (flow charts should be used)
- Clarity of lead agency role
- Clear escalation process to senior managers where risk is escalating and s42 and/or VARM have not been able to mitigate risk.

4.2. SASP should follow up on the recent safeguarding referral audit to identify if decision making is identified as an area for further work.

4.3. Following the new service model of the Adult Social Care front door, future Multi Agency Case File Audits should include safeguarding decision making as a key question.

4.4. SASP must produce a one-minute briefing as a reminder and reinforcement of defensible decision making.

4.5. SASP should ask organisation's safeguarding leads to evaluate how well professionals understand and make use of their role in complex decision making in safeguarding adults.

5. General Learning Briefing:

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

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

Appendix One:

Terms of Reference and Project Plan (Redacted)

Safeguarding Adults Review

Harris

Terms of Reference and Scope

1. Introduction

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

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

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

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

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

Condition 2 is met if—

(a) the adult is still alive, and

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

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

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

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

(b) applying those lessons to future cases.

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

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

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- Be proportionate according to the scale and level of complexity of the issues being examined;

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

2. Case Summary

Harris was a gentleman of British Asian origin who was 49 years old at the time that he was found deceased at home. Initially there were concerns that his death may have been suspicious due to implements that could have been weapons being found close to Harris. As there was no sign of any forced entry this was ruled out. Harris was known to a range of local services due to his mental health needs, his drug use and needs from a brain injury he received as a child. Some of those services had discharged Harris in the year before his death. Harris had been married but difficulties in the relationship and alleged domestic abuse from Harris towards his wife led to a breakdown in the relationship. Harris spent a period of time homeless in the year before his death. The coroner recorded a verdict of drug related death from opiate toxicity.

3. Decision to hold a Safeguarding Adults Review

The Safeguarding Adults Review Subgroup recorded a decision on 19 January 2021 that the criteria for a Statutory Safeguarding Adult Review were met under the criteria of a discretionary SAR (the adult's death was not caused by abuse or neglect including self-neglect but SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.) The

Independent Chair endorsed this decision.

4. Scope

The review will cover the period May 2019 until the date of death. This covers the area of most recent practice and multi-agency working to be analysed for learning. Further consideration will be given to the impact of any significant events outside of that time frame to give contextual information to the period under review.

5. Method

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

SASP chose to use a methodology that engages frontline practitioners and their line managers. Agencies are asked to review their own involvement, identifying strengths and areas for learning as well as recommendations. Those who were involved, alongside the authors of the agency reviews will then be invited to engage in Learning and Reflection Workshops to review all of the material and identify key themes and learning.

6. Key Lines of Enquiry to be addressed

In considering all of the key lines of enquiry please consider where practice strengths are identified.

6.1. History

6.1.1. How was history of Harris used to provide information related to the person that Harris was, include social history and life experiences that you are aware of from records and discussion with practitioners.

6.2. Assessment

6.2.1. Critically analyse the effectiveness of any assessments of Harris that your agency/service undertook within the timeframe of the review? Please include all types of assessments and in particular focussing on referrals and assessments in response to concerns about mental health, brain injury, drug use.

6.2.2. What did assessments conclude and what services were offered as a result? If no services were offered, or discharge was the conclusion from the assessment, please critique the rationale for this and where information was shared regarding your service's discharge of Harris.

6.2.3. Critically analyse your engagement and understanding of the impact and consequences on Harris when the GP became the continuing point of reference when services were discontinued (even if this happened before the timeframe of the review

discuss impact within timeframe)

6.2.4. How was Harris involved in assessments and what were his views on assessment conclusions?

6.3. Pandemic Impact

6.3.1. Following the national response to the Covid- 19 pandemic, please analyse the impact on Harris of any changes to services and/or practice.

6.4. Mental Capacity Act

6.4.1. How well was the Mental Capacity Act applied at points where it was appropriate?

6.4.2. Analyse the part played by the Mental Capacity in understanding Harris's capacity to make informed decisions about his assessment and care.

6.5. Safeguarding (including Domestic Abuse)

6.5.1. How well were safeguarding procedures applied to protect and safeguard Harris's well-being?

6.5.2. Critically discuss the effectiveness of the system to protect the partner of Harris and the children from the allegations that Harris was a perpetrator of domestic abuse. How effective was work with Harris as an alleged perpetrator in being a safeguarding mechanism in this case.

6.6. Homelessness

6.6.1. Provide examples of how Harris was supported whilst he was homeless and how well the system provided via the Homeless Reduction Act worked towards rehousing and positive outcomes for Harris.

6.7. Family and community

6.7.1. How well was Harris supported by his family and community. Identify areas where professionals involved family and community as appropriate.

6.8. Multi Agency working

6.8.1. In considering all the above, critically discuss how well agencies worked together to support and safeguard Harris. Provide evidence of where practice strengths were evident. Please include how well your agency understood the role of others and whether there were any apparent issues with eligibility criteria or funding of services.

6.8.2. Critically analyse information recording and sharing in this case and whether this was appropriate for the complexity of his needs.

7. Independent Reviewer and Chair

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

8. Organisations to be involved with the review:

- Adult Social Care (ASC)
- CCG for the General Practitioner (GP)
- Housing and Neighbourhoods Service including Housing Solutions
- Teaching Hospitals NHS Trust
- Health & Social Care NHS Trust – Various Services including:
  - Substance Misuse Service Opiates Team
  - Long Term Neurological Conditions Service
  - Adult Mental Health Early Intervention Service
  - Adult Mental Health Services - SPA
  - Community Brain Injury Rehab Team
  - Adult Autism & Neurodevelopmental Service
- Citizens Advice (CAB)
- Police
- Domestic Abuse Charity
- Personal Assistant providers and support
- Church ad registered Charity

Other services to be contacted: Children's Social Care

9. Family Involvement

A key part of undertaking a SAR is to gather the views of the family and share findings with them prior to publication. The author will contact family members as appropriate and invite them to be involved and meet with the author.

10. Parallel Proceedings

The inquest into the death of Harris is concluded; there are no other parallel proceedings

11. Project Plan dates:

	PROJECT TIMELINE	
1.	Scoping Meeting	02/07/2021
2.	Terms of Reference updated	02/07/2021
3.	Authors' Briefing	08/07/2021
4.	Agency Review Reports (ARRs) Due	03/09/2021
5.	Independent author QA's ARRs	06-08/09/2021
6.	Distribution of Agency Review Reports and associated documents to all Learning & Reflection Workshop/s attendees	10/09/2021
7.	Learning and Reflection Workshops Briefing via Teams	23/09/2021
8.	Learning and Reflection Workshop/s (3x3 hour themed sessions over two weeks)	28/09/2021 30/09/2021 08/10/2021

9.	V1 report Circulated to those that attended workshops.	5/11/2021
10.	Feedback on V1 due	19/11/2021
11.	V2 report circulated to panel (and workshop attendees for info only)	03/12/2021
12.	Panel meeting 1	17/12/2021
13.	V3 To panel	04/01/2022
14.	Panel Meeting to finalise report (V4) and work on Recommendations	WC 17/01/2022
15.	Virtual feedback and consultation to finalise report	TBC
16.	Presentation to SAB	FEB/March 2022