Cornwall and Isles of Scilly Adult Safeguarding Board

Safeguarding Adult Review - Gerry

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Contents

1. Introduction – Circumstances that Led to this Review

1.1 This Safeguarding Adult Review (SAR) was commissioned in 2023 by the Cornwall and Isles of Scilly Safeguarding Adults Board (CIoS SAB) following the death of a man in his late seventies , who for the purposes of this report will be referred to as Gerry. Gerry died in his home during November 2021. There was a significant history of contact with, and referral to agencies prior to his death. These included adult social care, police, fire service and primary health professionals.

Why was this case reviewed?

1.2 CIoS SAB commissioned a SAR to examine the circumstances and multi-agency response prior to Gerry's death, the reviewer was subsequently identified and commissioned. The SAB took the decision that, on the information presented at the time, the threshold for a SAR under section 44 of the Care Act 2014 was met. Under section 44 of the Care Act SABs must initiate a 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 more effectively to protect the adult.

1.3 The purpose of a SAR is not to apportion blame but capture positive learning to improve systems and professional practice for the future.

1.4 It is apparent that Gerry was an extremely private man who neither sought nor accepted professional help beyond some limited interaction with his GP. The material analysed for this review paints a picture of a man who was isolated but did not seek the company of others. He had the companionship of his dogs but there are no records of any family, friends or community ties. Gerry had no known next of kin.

1.5 The review has been supported and governed by the SAR sub-group of the SAB. The reviewer has presented periodic updates to them and provided draft reports for their consideration. Terms of Reference (ToR) were considered and agreed (attached at Appendix A).

Involvement of family members / their views

1.6 It is good practice to engage with the family of the subject when conducting a SAR. Unfortunately, in this case this has not been possible as there are no details of family members available, if indeed Gerry had any family. The reviewer has considered if Gerry had any close friends or community ties however there is no indication of any strong relationships within the information supplied. It is important that this review does its utmost to represent 'the voice' of Gerry, considering his lived experience when analysing key practice episodes.

Scope of the Review

1.7 The review focuses on a period from November 2020 to the date of Gerry's death in November 2021. This time was selected because this covers the period where a multi-agency approach to his issues could and should have been adopted following concerns raised by the GP practice and professionals who attended his home.

1.8 The review seeks to analyse the contact Gerry had with professionals for whom safeguarding is significant within their roles, examining the effectiveness of multi-agency working and its impact on Gerry's quality of life. Systemic issues will be considered to maximise the opportunity to learn and improve practice.

2. Methodology

2.1 There is no prescriptive methodology for a SAR, though it is now widely accepted that for multi-agency reviews a system-based approach is desirable. This review has relied upon a review and analysis of documents provided by agencies, predominately written reports (chronologies and individual management review reports (IMRs) and statements made in the Coronial process. Key practice events have been identified and reflected upon.

2.2 In addition to documents provided, the reviewer has spoken directly to individuals involved in this case. It is extremely helpful to the review to complete these interviews. It allows far greater understanding of context and affords the opportunity to gain a closer view of the lived experience of Gerry. It is important to recognise that these exchanges can be impactful for individuals, this review is more effective and impactive because of the time and information shared. The reviewer would like to thank those that took the time to speak with him. All were extremely professional, open and honest about circumstances that were obviously impactful to them. Additional information was also supplied by Adult Social Care (ASC). This information detailed the changes that had already been put in place to improve practice an overview of these improvements is provided in section 4 of this report.

Comment – The fact that Adult Social Care had made changes to practice based on learning identified from this case prior to the outcome of this review is good practice. Where agencies recognise that systemic improvements can be made to improve practice it is essential that they do so immediately, rather than waiting for the completion of a SAR.

Independence and expertise of the commissioned reviewer

2.3 The independent reviewer, Chris Robson, is an experienced independent investigator across Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews. He is the Independent Chair and Scrutineer for four Safeguarding Children Partnerships. He has a significant police background, much of which was spent directly involved in multi-agency safeguarding work. He has worked on high profile national cases and led the Metropolitan Police Service response to all statutory reviews between June 2015 and November 2017. He is a published author of several safeguarding reviews, including SARs.

3. Summary of the Case

3.1 This SAR examines the circumstances that led to Gerry's death. He had a history of health needs including heart disease, chronic kidney disease, a type of cancer and type 2 diabetes which led to his GP practice trying to engage with him. Gerry was reluctant to engage with health professionals, in fact it is noted by the GP that non-engagement started in the middle of 2017. He was clearly a very private person who expressed a view that he did not want people intervening in his life. His conscious decision to be private no doubt added to his isolation. The review has found no evidence that he received any support from family, friends or any other group. It appears that he preferred a solitary lifestyle enjoying the company of his dogs.

3.2 Gerry was a man in his late seventies who resided alone in rented accommodation in a town in Cornwall. He had some medical issues that required monitoring from his GP. It appears that Gerry was reluctant to engage with his doctor and this resulted in safeguarding concerns being raised, specifically around self- neglect. Specific visits and practice episodes will be dealt with later in this report.

3.3 In November 2020 the GP practice made a home visit, concerned for Gerry's welfare. They were unable to gain entry, so the police and fire service also attended. Gerry was seen and was unhappy about the visit. A referral was made to Adult social care who decided that a needs assessment should be carried out under the Care Act.

Comment - The Care Act 2014 provides the legislative basis for dealing with adults who need care and support. The Act is published, in full, on the government website and there is helpful guidance for professionals to assist with interpretation and application of the Act. Section 9 of the Act details the Local Authority's (LA) responsibility for assessing an adult's need for care and support. This review will not set out the legislation in full, but the reader should know that Section 9 sets out that where it appears to a LA that an adult may have needs for care and support, the authority must carry out a needs assessment. This assessment must assess whether the adult does have needs for care and support, and if the adult does, what those needs are.

In this case Section 11 of the same Care Act also needs to be considered. This states that where an adult refuses a needs assessment, the LA concerned is not required to carry one out. There are caveats to this including the individual's capacity, including 'the adult is experiencing, or is at risk of, abuse or neglect'. This section of the act should have resulted in greater consideration of alternatives for engagement with Gerry.

3.3 Following several unsuccessful attempts to contact Gerry by telephone and letter a home visit was conducted in late April 2021. Gerry was spoken to, declined support but was assessed as having capacity. He appeared unhappy at contact from agencies including his GP, Fire Service and Adult social care. The social worker who undertook the visit assessed him as having the capacity to make decisions.

3.4 In September 2021 Police and the Fire service made separate new referrals to Adult social care detailing concerns around hoarding and self-neglect. Another request to

undertake an assessment of needs was made and attempts to contact Gerry were made but were largely unsuccessful.

3.5 In September 2021 a referral for care management was triaged to 'Priority Allocation' resulting in a social worker being allocated the following week. In October the social worker made several attempts to contact Gerry without success. Their next proposed step was to write to him to book an appointment for a needs assessment.

3.6 In November 2021 the social worker visited Gerry's home. They were unable to get a response and this visit was followed up by a letter to him. The review has seen no evidence of a joint visit being considered other than re-active responses to non-engagement.

3.7 Later that month Gerry was found deceased at his home address. Police and ambulance services had attended following concerns raised by his landlord. The cause of death could not be determined because Gerry's body had decomposed. His body's physical appearance and the condition of the house was such that it caused significant impact to the professionals who discovered and dealt with him. I have spoken to those professionals who attended the address and found Gerry deceased and the impact involved in this cannot be underestimated.

4. Key Practice Episodes, Events and Agency Engagement in this Case

Engagement with his GP and Hospital

4.1 Gerry was registered with a local GP near his home address. The GP was attempting to monitor his health owing to several medical conditions. It is noted that as early as 2017 he began to disengage from medical services. I have been informed that when he did attend his conversation was monosyllabic and he was difficult to speak to or engage with. In mid-2018 the GP surgery began to write to him requesting that he make appointments for appropriate monitoring visits. In Early December 2018 Gerry attended the surgery for an appointment with a doctor. He explained that he had been in Cyprus for 3 months looking after his sister who had unfortunately passed away. The GP noted that Gerry was dishevelled and thought that he was a 'vulnerable adult' at the time of the appointment. He was asked for his next of kin details, but none were provided. There followed some clinical reviews of Gerry's medication with changes made without him being seen.

Comment – the interaction between GP and Gerry offered an opportunity for greater engagement. It would have been clear from notes that such opportunities were rare with this person. Good practice would have been to make a referral to Adult social care if the GP felt there were safeguarding issues. This was a missed opportunity to engage with Gerry.

4.2 Concerns regarding non-attendance for blood tests and monitoring continued until, during November 2020, the GP's practice asked their paramedic to make a home visit to Gerry. Unable to get a response the paramedic made enquiries with the neighbours. It was apparent that no-one had seen Gerry for 3 days. Police, the Ambulance Service and Fire Service were called to gain entry to the premises. Gerry did eventually appear and seemed to

be in reasonable health. He told professionals that he was a very private person and didn't always want to see people. The GP surgery raised a safeguarding concern as they believed Gerry was vulnerable. This resulted in calls from Adult social care and an exchange of information.

Comment – It is clear from reports provided that the GP's surgery did make referrals to Adult social care and had subsequent conversations with them, this was good practice on their part. The home visit made by the paramedic, efforts to speak to neighbours and this individual's tenacity to ensure Gerry was seen should also be seen as good practice.

4.3 Gerry was also under the care of the Royal Cornwall Hospital Trust for medical conditions, pacemaker checks that required monitoring. Their records paint a similar picture to those of the GP practice with missed appointments over a prolonged period, starting in summer 2018. It is essential that those tasked with assessing risk see non-engagement as a significant factor, worthy of consideration.

Recommendation 1 – The SAB should seek reassurance from Royal Cornwall Hospitals NHS Trust (RCHT) /Cornwall Partnership NHS Foundation Trust (CFT) that NHS England guidance "Reducing Did Not Attends (DNAs) in Outpatient Services" has been considered and implemented locally. The SAB should also seek assurance from all partners that similar policies are in place to identify DNAs which consider the "why" and what actions should be taken to effectively engage with and protect these vulnerable adults .

Comment – The implementation of "Right Care, Right Person" policy nationally by police services should be monitored to assess its impact when individuals are the subject of consistent DNAs.

Fire and Rescue Service and Police Engagement

4.4 Both Police and Fire Service engaged with Gerry when called to do so by other agencies. They responded to welfare concerns for him on more than one occasion. In September Cornwall Fire and Rescue Service received a Home Fire Safety Check referral for Gerry from Police. The Police, having been called to Gerry's home address by his landlord, discovered that the property was in extremely poor condition. The property was completely overgrown with brambles resulting in no access to the front door or any of the windows. There were dog faeces throughout and evidence of hoarding. Officers climbed over a rear gate and spoke with Gerry through a window. He was happy to speak with them but would not allow them entry to the property.

4.5 Fire crew visited the property to carry out a Home Fire Safety check. They were unable to get Gerry's attention by knocking on the door, so they climbed over the rear gate and shouted through the back door. They were able to hear him calling from the bedroom, so they entered. Gerry was in bed unwell but was happy for the crew to enter the property and he engaged well with them. The crew also went over and above to support him with the care of his animals.

4.6 On returning to the station the fire crew completed a safeguarding referral that was submitted to Adult Social Care. Unfortunately, this referral was not delivered because an incorrect email address was used. This review acknowledges that it is the individual's professional responsibility to ensure the referral made is received. This should be done by seeking an acknowledgement of receipt. Further referrals were made to Environmental Health and the RSPCA due to concerns about the animals on the property and the extremely poor living conditions. The crew noted that this was the worst property they had ever entered and wrote on the safeguarding referral that the property was unfit to live in and hazardous to human health. The property displayed extreme hoarding, with animal faeces and urine throughout. The crew described the floor as 'squelching as you walked across it'. The pictures taken of the house by the fire crew show that Gerry was clearly in need of support.

Comment – There is evidence of good communication between the Police and Fire & Rescue Service regarding safeguarding concerns. It also appears that as this is one of the only times Gerry spoke and responded with professionals this may have been an opportunity to introduce other agencies, capitalising on Gerry's engagement. It is also important to note that both police officers and fire fighters showed real tenacity to ensure they gained entry / spoke to him. This was good practice, with individuals following their professional curiosity to ensure they had spoken to Gerry.

There are questions regarding the referral process, including feedback to front line officers and a learning culture that the Fire Service should consider. The fire Service may wish to consider putting a system in place that considers the impact of learning from internal reviews and SARs.

Referrals were made to Environmental Health and the RSPCA. This shows a good awareness across the Partnership of appropriate resources to involve in this case. However, the fact that a referral that was written for Adult social care but never reached them because it was wrongly addressed has rightly been raised as a concern. Action has been taken to ensure this does not happen again with the introduction of a new online referral portal.

Recommendation 2 – The SAB should reassure itself that there is appropriate scrutiny of the online referral portal, this should include seeking the feedback of those with "lived experience" of making safeguarding referrals through the portal to test its effectiveness and identify any potential improvements. A system should be in place that monitors referrals made, to ensure they are reaching the appropriate operational staff and of sufficient quality to inform risk assessments and decisions made.

Response to referrals

4.7 Referrals into Adult social care regarding Gerry were first raised in November 2020. This followed previously described incidents where professionals attended his address after concerns were raised for his welfare. Observations regarding the state of the property and

self-neglect were shared and an initial assessment was made. This assessment resulted in a recommendation that a section 11 assessment was the most proportionate response.

4.7 In late April 2021 a social worker undertook a home visit and spoke to Gerry. He stated that he was unhappy with what he perceived to be the GP sending people to his house. He was clear that he did not want help and was assessed as having capacity.

4.8 In mid-September Police made a referral to Adult social care about Gerry living in squalid conditions with evidence of hoarding and fire risk. The triage team recommended an initial intervention under care management with an assessment of Gerry's care and support needs. An Adult Risk Management (ARM) approach was recommended. This approach provides professionals with a framework to facilitate effective multi-agency working with adults who are deemed to have mental capacity and who are at high risk due to severe self-neglect, refusal to engage with services or when someone is being targeted by an unknown third party. I have found no evidence that this approach was used.

4.9 In October 2021, some 5 weeks after the referral was made, a newly posted Case Co-Ordinator who had been allocated the case tried to make contact with Gerry, this was unsuccessful. It appears that these attempts were made by telephone with a note that if they continued to be unsuccessful, they would ask admin to write to Gerry to book an appointment for an assessment.

Comment – Given Gerry's history of lack of engagement it is clear that the attempts to contact him detailed above were not best practice and were unlikely to result in a successful needs assessment being conducted. The review has been provided with the context in which this decision was made. The Adult social care team had 18 people in it with a 'waiting list' of 300 cases. Work was episodic and high demand had an impact, making building trusting relationships with people difficult. The review acknowledges this, but good practice would have been to have face-to-face contact with Gerry.

The review has also been provided with a significant number of steps taken to improve practice that arise from local learning in this case. These include:

- ***Referrals are now risk assessed by experienced social workers.***
- ***Self-neglect referrals are now recorded as priority 1 which results in urgent allocation***
- ***Duty teams will make welfare visits where significant risks are highlighted***
- ***Reflective caseload supervision that records all case needs, risks and actions***
- ***Self-neglect and Hoarding policy has been discussed at all team meetings and re sent to all team members***
- ***Information regarding s11 assessments has been sent to all operational staff***
- ***Workshops on self-neglect and s11 are being undertaken***
- ***Self-neglect cases discussed prior to closure unless closed via the ARM process***
- ***Fire Service are now represented in the Multi Agency Safeguarding Hub***

It is important that Adult social care monitor the impact of these changes. Where positive impact is noted then wider systemic changes may be appropriate.

5. Summary of Findings

5.1 This review has identified key findings when analysing the information provided. It is important to remain focussed on the purpose of this review when considering these findings. This review seeks to afford the SAB the best opportunity to consider learning that arises from this case, to improve practice and outcomes for vulnerable people in the future. This review does not seek to apportion blame and where there is learning for individuals this will be the responsibility of their agencies. Many of the findings have been discussed at length in this report. This chapter will summarise them to allow the reader to focus on specific areas for improvement.

1. Early engagement and building trusting relationships with adults at risk of abuse or neglect.

5.2 This case illustrates the need for all professionals to engage at the earliest opportunity with adults at risk of abuse or neglect, to be aware of their lived experiences and to develop trusting relationships with them. Gerry was a private man who actively avoided engaging with agencies and individuals who would have access to resources that may have been able to offer assistance to him. It was clear that his isolation, at least in part, resulted in self-neglect which left him living in squalid conditions. Professionals were aware of his non-engagement and he was described as dishevelled and vulnerable as early as 2018. This perceived 'lower level' concern, if identified and dealt with at an early stage, can reduce the risk of escalation to more serious levels of self-neglect.

Recommendation 3 – The SAB to obtain assurance from all local agencies current self-neglect training to ensure that it is fit for purpose and identifies opportunities for practitioners to recognise safeguarding risks at an early stage, the benefits of early engagement and building trusting relationships. A multi-agency audit will "test" and measure the impact of completing this training on professionals practice should also be implemented.

2. Information exchange amongst professionals and its pivotal part in risk assessment

5.3 This case illustrates the benefits of good information exchange, and how, if used correctly, it can result in the best possible multi-agency response to safeguarding issues. There is clear evidence of information exchange between agencies following direct contact with Gerry. However, this review has found that despite this exchange there was little application in terms of risk assessment. The ARM process was not used and there is no evidence of any co-ordinated multi-agency meetings taking place to consider risk to Gerry.

3. Dealing with people who do not want to engage

5.4 It is abundantly clear that Gerry actively sought not to engage with professionals. Indeed, he criticised people who visited his house and blamed agencies for what he perceived as not respecting his privacy. It is an incredibly difficult challenge to engage with a person who has capacity but is clear in their wish not to speak to professionals. That said it is often the case

that those who are at risk of self-neglect, isolation and other safeguarding issues who present in this way. There is some evidence of limited engagement in this case (fire and rescue visit, GP appointment) and it is important to recognise these as opportunities. Professionals carry substantial workloads, and it is often difficult to find time to engage with those who appear reluctant to accept help. It is essential that the SAB promotes a culture where operational staff are given time and training to develop their skills in this key area. The investment in the short term will reap substantial benefits.

Recommendation 4 – The SAB should promote existing multi-agency training and guidance to improve multi-agency staff response to non-engagement. This should include reflective sessions on successful approaches and sharing learned skills across all agencies. SAB assurance to agency practice approaches to non-engagement should be sought through multi-agency case audits, supervision feedback, multi-agency quality assessment and impact of training and any other method thought appropriate.

4. Approach to and assessment of people who do not want to engage

5.5 This case illustrates the importance of having appropriate policy and procedures in place to deal with people who do not engage with professionals. Gerry had a significant history of non-engagement. When professionals assessed it as necessary to contact him they did so via the telephone. Whilst this is obviously the most efficient way to contact an individual it was obvious in this case that it was unlikely to be successful. The next step proposed was to write to him, inviting him to make an appointment for an assessment. Given his history it is highly unlikely that this would have resulted in Gerry contacting Adult social care. It is apparent from the documents provided that the only way to speak to Gerry was to visit him in person and be persistent in the approach. The visits that did follow were the correct course of action.

5. Trauma informed approach to staff involved in the case

5.6 The condition of Gerry, his dogs and house when he was found were such that the risk of trauma to staff was significant. This was then compounded by the trauma individuals were subject to when he died. We should always consider the impact this has on those who were involved in such cases. Whilst it is clear that those who saw the conditions he was living in may be impacted, the fact that he died in these conditions is likely to extend this trauma beyond those who had direct contact. It is apparent from the documents provided that some agencies have excellent provision for staff, affording them an opportunity to de-brief and seek appropriate support when impacted. It is essential that all members of the Partnership have the same trauma informed opportunities when they have dealt with similar circumstances.

Recommendation 5 – The SAB assures itself that there is sufficient provision for staff who are exposed to trauma because of dealing with cases that involve significant stress.

6. Conclusion

6.1 There is little known about Gerry, he appears to have lived alone with his dogs and had no known relatives or friends . He had very little interest in engaging with professionals or services. This left him vulnerable to self-neglect with his home being described as squalid and unfit for human habitation, where his body was found in a decomposed state.

6.2 The reasons for Gerry's lack of engagement are not known. In fact, there is little evidence of anyone asking him why he did not want to attend medical appointments or what could be done to remedy the issue. The exception appears to be his explanation regarding time spent looking after his sister.

6.3 Concerns were raised regarding his apparent self-neglect by his GP and subsequent professionals who attended his home address. These led to Adult social care making the decision that his needs required assessment. There was no multi-agency meeting to consider risk and efforts to contact Gerry were predominantly via phone and letter. The lack of multi-agency planning and risk assessment led to a single agency approach by Adult social care. This approach did not recognise the severity of risk and a more robust, tenacious approach to contacting Gerry was lacking.

6.4 This review has highlighted an opportunity for single agencies and the SAB to assure themselves that improvements that have been introduced post Gerry's death are effective and consider impact. Now would be an ideal time for agencies and the SAB to take stock, particularly in key areas including referral pathways, risk assessment, non-engagement and trauma informed practice. This review makes recommendations that seek to offer the SAB opportunities to improve multi-agency safeguarding when similar issues present again.

Chris Robson

Independent Reviewer

Table of Recommendations

Recommendation 1
The SAB should seek reassurance from Royal Cornwall Hospitals NHS Trust (RCHT) /Cornwall Partnership NHS Foundation Trust (CFT) that NHS England guidance "Reducing Did Not Attends (DNAs) in Outpatient Services" has been considered and implemented locally. The SAB should also seek assurance from all partners that similar policies are in place to identify DNAs which consider the "why" and what actions should be taken to effectively engage with and protect these vulnerable adults .
Recommendation 2
The SAB should reassure itself that there is appropriate scrutiny of the online referral portal, this should include seeking the feedback of those with "lived experience" of making safeguarding referrals through the portal to test its effectiveness and identify any potential improvements A system should be in place that monitors referrals made, to ensure they are reaching the appropriate operational staff and of sufficient quality to inform risk assessments and decisions made.
Recommendation 3
The SAB to obtain assurance from all local agencies current self-neglect training to ensure that it is fit for purpose and identifies opportunities for practitioners to recognise safeguarding risks at an early stage, the benefits of early engagement and building trusting relationships. A multi-agency audit that will "test" and measure the impact of completing this training on professionals practice should also be implemented.
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The SAB should promote existing multi-agency training and guidance to improve multi-agency staff response to non-engagement. This should include reflective sessions on successful approaches and sharing learned skills across all agencies. SAB assurance to agency practice approaches to non-engagement should be sought through multi-agency case audits, supervision feedback, multi-agency quality assessment and impact of training and any other method thought appropriate
Recommendation 5
The SAB assures itself that there is sufficient provision for staff who suffer trauma because of dealing with cases that involve significant stress of any kind.

9. Appendix A - Terms of reference (TOR)

Gerry – Safeguarding Adults Review (SAR) Terms of Reference/Key lines of enquiry:

Background:

Gerry was a man in his late seventies that resided alone. He had some medical issues that required monitoring from his GP. It appears that Gerry was reluctant to engage with his doctor and this resulted in safeguarding concerns being raised, specifically around self-neglect.

Following initial referrals being received in January 2021 Adult Social Care made a decision to instigate a Section 11 assessment. The first attempt to contact Gerry was made in mid-March, some 10 weeks post the initial referral.

Following several unsuccessful attempts to contact Gerry by telephone and letter a home visit was conducted in late April 2021. Gerry was spoken to, declined support but was assessed as having capacity. He appeared unhappy at contact from agencies including his GP, Fire Service and Adult Social Care.

In September 2021 Police and the Fire service made separate referrals to Adult Social Care detailing concerns around hoarding and self-neglect. Another request to undertake an assessment was made and attempts to contact GB were made, including a home visit during November 2021. No response was received.

During November Gerry was found deceased at his home address. Police and ambulance services had attended following concerns being raised by his landlord.

The Safeguarding Adults Review (SAR):

This safeguarding adult review is needed to establish what lessons can be learned from how agencies worked individually and together to safeguard and protect Gerry.

The purpose of the SAR is **not** to hold any individual or organisation to account and other processes exist for that purpose. The focus of the review is to identify any lessons to be learnt from the case and apply those lessons to future cases.

The areas that this review will address are set out below. With regards to lessons learned, the review will set these out very clearly as a summary and set of recommendations which will be produced at the end of this review. It is expected that these recommendations and learning points will be taken forward and regularly monitored.

This SAR review follows the process and principles as set-out in **SAR Quality Markers** that are intended to support commissioners and lead reviewers to commission and conduct high quality reviews. Covering the whole process, they provide a consistent and robust approach to SARs. The Quality Markers are based predominantly on established principles of effective reviews / investigation as well as experience, expertise, and ethical considerations.

This review seeks to:

- Establish if there is learning that arises from Gerry's circumstances prior to his death. This will include a review of multi-agency work and its effectiveness to safeguard Gerry.

- Examine multi-agency communication and information exchange in this case.

- Systemic issues – Review existing policy/procedures that deals with the issues, consider barriers including training, supervision, support, multi-agency safeguarding and resources that may have affected the outcomes.

- Examine risk management processes and implementation.

- Consider the response to safeguarding referrals including methods of contact with individuals who are the subject of concern.

- Consider the assessment structure, its purpose, implementation, and effectiveness.

- Examine policy, procedures, and practice where adults are reluctant to engage with safeguarding partners.

- Where possible to engage with Gerry's family, friends, and community to seek their views.

- Highlight good practice that can be shared and learned from.