olderminds matters

Safeguarding Adult Review

Jack

Note: Jack is a pseudonym used for the purposes of this Report.

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1. Introduction

1.1 Barnsley Safeguarding Adults Board initiated this Safeguarding Adult Review (SAR) in April 2018. It followed an incident when a 68 year old man died in a house fire in early 2018.

1.2 The aim of a SAR is to promote learning and improvement action in order to prevent future incidents involving death or serious harm. The Care Act 2014[1] states the following:

(1) An[2] 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.

(2) 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).

(3) 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.

(4) An[2] 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).

1.3 In this case an adult with care and support needs was subject to self-neglect. This Overview Report provides an overview of the deliberations and recommendations of the SAR/ DHR Panel, Independent Chair/ Author, and a learning event, drawing overall conclusions and recommendations from the information and analysis contained in Individual Management Reviews (IMRs) and other information supplied.

1.4 Contributors to the Report include the following:

- Adult Social Care, Barnsley (ASC)
- The GP practice
- South West Yorkshire Partnership NHS Foundation NHS Trust (SWYPFT)
- South Yorkshire Police (SYP)
- Jack's Family

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[1] See http://www.legislation.gov.uk/ukpga/2014/23/section/44

[2] "An" is grammatically incorrect but is retained here, in line with the original as quoted.

1.5 This Review seeks to capture as much learning as possible for the agencies involved.

2. Circumstances that led to a Safeguarding Adult Review being undertaken

2.1 On a date in January 2018 a 68 year old man, Jack, the subject of this Review was found dead in his bedroom when the Fire and Rescue Service attended a house fire in Barnsley.

2.2 Prior to that, Jack had twice been the focus of a safeguarding concern in January and August/ September 2017. Both concerns had identified issues of self-neglect and poor living conditions.

2.3 An initial meeting to commission the Independent Chair/ Author and identify Terms of Reference took place on 15 March 2018.

2.4 In April 2018 Barnsley Safeguarding Adults Board formally initiated this Safeguarding Adult Review (SAR) and appointed an Independent Chair/ Author.

2.5 The timescale for the review was agreed as December 2013 to the point of death for IMRs but with information prior to that to be sought from specified agencies.

2.6 Three agencies were known to be involved with the Jack in the period preceding the incident:

Barnsley Adult Social Care: ASC
The GP Surgery
South Yorkshire Police: SYP

2.7 A further agency had been involved at an earlier stage and was asked to provide information relating to their prior contact with JACK:

South West Yorkshire Partnership NHS Foundation Trust: SWYPFT

2.8 Information about ASC's involvement with Jack's mother was also requested to be included within the ASC IMR.

2.9 The detailed process of the SAR is set out under heading 4. Process of the Safeguarding Adult Review.

2.10 Independent Chair/ Author

The Author of this report is by professional background a psychiatrist and systemic therapist specialising in work with older adults. She has broad clinical and multi-agency experience in the North West and West Midlands. She has acted as Chair and/or Author, and expert medical adviser/ consultant to Domestic Homicide Reviews, Serious Case Reviews, Safeguarding Adult Reviews, and Local Case Reviews in the past. She has no connections or ties of a personal or professional nature with the family, with Barnsley Metropolitan Borough Council or with any other agency participating in this review.

3. Terms of reference

3.1 The terms of reference for the SAR are set out below.

3.2 Terms of reference for the SAR

To review the involvement of agencies with Jack from December 2013 to the point of his death with the intention of:

- Identifying if agencies complied with their policies and procedures that existed at that time.
- To identify any gaps in processes, policies and procedures including record keeping
- To identify any learning opportunities that can be identified by reviewing this case
- To identify any areas of good practice

3.3 The terms of reference for the Individual Management Reviews (IMRs) are set out below.

3.4 Terms of reference for IMRs

To review the involvement of agencies with Jack from December 2013* to the point of his death with the intention of:

- Identifying if agencies complied with their policies and procedures that existed at that time.
- To identify any gaps in processes, policies and procedures including record keeping
- To identify compliance with relevant legislation and guidance (including - Care Act, Mental Capacity Act etc. and Making Safeguarding Personal)
- To identify any learning opportunities that can be identified by reviewing this case
- To identify any areas of good practice

*The covering letter set out the specific start date of request for information by agency.

4. Process of the Safeguarding Adult Review

4.1 Process followed

4.1.1 An initial meeting took place on 15 March 2018 between the Adult Safeguarding Board Chair, Manager and independent Chair/ Author to agree the process of the SAR, subject to later approval.

4.1.2 Terms of reference for the SAR and for IMRs were finalised by email.

4.1.3 The members of the SAR/ DHR reference group are set out below:

Name	Role	Organisation
Sharon Baldwin	Case & Policy Review Officer, Public Protection Unit	South Yorkshire Police
Cath Erine	Adult Safeguarding Board Manager	Barnsley Metropolitan Borough Council
Sarah MacGillivray	Designated Nurse, Safeguarding Adults and Patient Experience	NHS Barnsley CCG
Julie Warren-Sykes	Associate Director of Nursing and Professionals, Patient Safety	South West Yorkshire Partnership Foundation NHS Trust
Jane Wood	Head of Service – Adult Social Care	Barnsley Metropolitan Borough Council (BMBC)

4.1.4 The timescale for IMRs was set as December 2013 to the date of Jack's death and the date for return of IMRs was agreed as 27 April 2018.

4.1.5 Individual Management Reports and chronologies were requested and provided by the following:

Agency	Abbreviated as	Author	Quality Assured by
Adult Social Care, Barnsley	ASC	Jane Wood, Head of Service	Lennie Sahota, Interim Service Director BMBC
GP practice	GP	Michelle Field, Practice Manager	Dr SC Bridger, GP, Practice Safeguarding Lead
South Yorkshire Police	SYP	Sharon Baldwin, Case & Policy Review Officer, Public Protection Unit	Peter Horner, Delivery Unit Manager

4.1.6 Additional information was requested from and provided by

Agency	Abbreviated as	Author	Quality Assured by
South West Yorkshire Partnership Foundation NHS Trust	SWYPFT	Carol Morgan, Specialist Advisor for safeguarding Adults.	Julie, Warren-Sykes, Associate Director of Nursing and Professionals, Patient Safety

4.1.7 A SAR/ DHR reference group was held on 10 May 2018 to go through the IMRs and identify any further information needed and any areas needing further clarification.

4.1.8 At this stage further information was sought from the Noise Abatement Team, the Care Home where Jack's mother became a resident before her death, and Safer Neighbourhood Services.

4.1.9 A further SAR/ DHR reference group meeting took place on 5 June 2018 to examine additional information received following the May meeting and start to plan a Lessons Learned meeting.

4.2 Family Involvement

4.2.1 The Independent Chair/ Author and the Safeguarding Adults Board Manager carried out a joint home visit to meet with family on 8 May 2018 in order to ask about Jack, background information, and to invite family perspectives.

4.2.2 The Report and learning from the SAR was shared with family prior to publication of the Report at a second meeting on 24 July 2018.

4.2.3 The section headed Background under 5. Facts of the individual case is drawn from information contributed by family.

4.3 Process of finalising the Report

4.3.1 A Lessons Learned meeting was held at Barnsley Town Hall on 19 June 2018.

4.3.2 A draft of the Report was taken to a SAR/ DHR Panel meeting on 17 July 2018.

4.3.3 The Report was then taken to a Panel meeting on 3 September 2018 and further changes were agreed.

4.3.3 The final document is to be submitted to the Adult Safeguarding Board on 13 September 2018 and the next step is to create an action plan to be monitored through Barnsley Safeguarding Adults Board.

5. Facts of the individual case

5.1 On 1 January 2018 a neighbour made a 999 call and the fire and rescue service, ambulance service and police attended a house fire at Jack's address. When crews arrived the ground floor of the property was well alight and Jack was found deceased in the bedroom by the fire service. He was declared dead at the scene.

5.2 Jack was a white British man who lived alone at an address in Barnsley. At the time of his death he received no support from local agencies. He worked as a teacher in early adulthood and had married and had one daughter. His wife left him after about 3 years of marriage and after that he lived alone. For some of his life he was a practising member of a local church. Until his mother died she supported him and after that his main support was his younger brother who also lives locally.

5.3 He came to the attention of South Yorkshire Police (SYP) on several occasions and on three occasions he was referred to Barnsley ASC.

5.4 The issue of self-neglect was first flagged to ASC in January 2017 when a Department for Work and Pensions (DWP) visiting officer contacted ASC because of concerns about Jack's living conditions and neglected appearance.

5.5 Outline Chronology of Key events

5.5.1 The edited chronology below highlights key events over the period December 2013 to January 2018 with additional information relating to Jack's contact with SWYPFT and his mother's health and social care added.

5.5.2 The pattern evident is that Jack kept to himself and did not engage with services unless he had a clear reason to do so. He neglected himself and been reluctant to allow people into his home for a number of years.

5.5.3 Outline collated and edited chronology

Note: the shaded area in the chronology sets out information provided by other agencies, which did not submit an IMR, in response to questions from the SAR/ DHR Panel.

Date	Agency	Event Summary and relevant observations
17/12/2003	SWYPFT	Referred by GP as an urgent assessment to the Community Mental Health Team (CMHT). Seen in clinic. Jack had stopped claiming benefits and presented in a neglected state. He was prescribed Chlorpromazine[3] by GP. The reason for the prescription was that he was 'hearing voices and had been for five years plus'. These were predominately internal second person auditory hallucinations though at times they were third person and external. It was noted that he had used cannabis and hallucinogenic drugs in the 1960's for a brief period. The psychiatrist determined that Jack did have a psychotic illness and suggested that this had been present for possibly over ten years and therefore prescribed Olanzapine[4]. There is information on psychotic illness and depressive episodes.
2003	GP records	Record a diagnosis of schizoaffective disorder.
March 2004	SWYPFT	Jack's anti-psychotic medication was changed following a Care Programme Approach review.
July 2004	SWYPFT	Written notes record a period where Jack was experiencing suicidal thoughts and his mental health deteriorated resulting in an increase in the symptoms of his illness; an increase in his auditory hallucinations. He was encouraged to attend Moorland Court, a Day Centre for service users with mental health issues and a local community drop in run by the CMHT. His mood and mental health improved due to the increased input and although his voices were still present, he was able to cope.
September 2004	SWYPFT	His anti-psychotic medication was increased and an anti-depressant medication started.
October	SWYPFT	Information in notes of an Occupational

[3] An anti-psychotic medication used to treat schizophrenia and other psychotic illnesses.
[4] An anti-psychotic drug treatment used to treat schizophrenia and other psychotic illnesses.

2004		Therapist (OT) assessment carried out between 6/10/04 and 19/10/04: Jack lived alone in a terrace house in close proximity to local amenities, and within walking distance of his mother's house. His mother supported Jack with many aspects of daily living. His house was noted to have few modern facilities, no central heating and no running water. There was a cooker but it was not connected. There was stone flooring in the home. The only modern appliances noted were a small electric grill and hot plate. The OT carried out a skills assessment at Jack's home and the Therapy kitchen at the Department of Psychological Medicine within the Barnsley hospital. It was noted that Jack was able to budget, shop and prepare a meal. However although he had the basic skill level, he did not have the amenities at home to prepare anything other than basic snacks. When questioned regarding the ability to prepare food, Jack stated that he did not want to acquire the appropriate equipment, as his mother enjoyed doing his cooking and attending to his laundry. Jack used an open fire "when necessary".
December 2004	SWYPFT	Written notes record that Jack's mood was objectively brighter and thought disorder was no longer evident. The voices were still present but not particularly distressing. The medication prescribed was fluoxetine[5] and risperidone[6]. Jack received support from a support worker from CMHT to facilitate socialisation, and this continued for approximately 12 months.
June 2005	SWYPFT	Written notes record that his 80 year old mother attended outpatients with him. He was compliant with the support plan and was attending a drop in day centre and had a place at a mental health day centre.
17/1/2006 to 25/9/2007	SWYPFT	Managed through outpatient appointments with a psychiatrist.

[5] Fluoxetine is an anti-depressive drug used to treat depressive illnesses.
[6] Risperidone is an anti-psychotic drug used to treat schizophrenia and other psychotic illnesses.

February 2007	SWYPFT	In a letter it was noted that Jack was prescribed risperidone, fluoxetine and procyclidine[7]. Jack had been receiving these from his GP, appeared to be complying, and was in agreement with its continuation.
24/4/2007	SWYPFT	Communication with a South Yorkshire Police officer from the Firearms Licensing department. Details were limited in the written notes, but suggest that Jack was asked to withdraw his firearms application and to surrender 2 shotguns.
29/5/2007	SWYPFT	Written notes record that Jack had surrendered his firearms. The Consultant wrote to ask the GP to take over Jack's care in primary care.
14/8/2007	SWYPFT	The GP sent a letter confirming agreement that Jack be discharged back to primary care.
25/9/2007	SWYPFT	Jack last seen in outpatients and care was transferred back to his GP. It was noted he appeared stable in mental health, was focused, did not appear preoccupied, and was not responding to stimuli. No concerns noted. It was recorded that he would see his GP regularly: therefore he was discharged back to his GP.
13/12/2010	ASC	Jack's mother was referred to Barnsley Adult Social Services for assessment and practical assistance with activities of daily living.
11/5/2012	GP Practice	GP surgery appointment. Mental health review, no problem with medications, no side effects, mood stable, requested baseline bloods.
24/7/2012	ASC	Jack's mother entered permanent care.
8/2/2013	GP Practice	GP surgery appointment. Jack stated was fully compliant with medication. Discussed drinking, as drank a bottle of whisky and fell on face, suffered bilateral periorbital haematomas. Jack stated it was a one off, smelled of stale alcohol, looked self neglected, denied any problems.
5/12/2013	SYP	Safeguarding Adult referral detailing concerns for Jack in relation to his mental wellbeing and alcohol use having been dealt with for theft of alcohol in Barnsley town centre. Officers speaking to Jack were advised by his brother that Jack suffered from schizophrenia and hadn't had a drink for several months. Brother reported being concerned for Jack who was not

[7] Procyclidine is a drug often used alongside anti-psychotic medication to treat side-effects of anti-psychotic drugs.

		coping following their mother going into residential care 12 months prior to the incident.
5/12/2013	ASC	Referral sent to CMHT.
6/12/2013	ASC	On receipt of referral, CMHT informed ASC not known to their services. Referral sent to appropriate adult locality team.
9/12/2013	ASC	Established Jack known to Central CMHT therefore passed to them. Case closed: no further action by ASC as passed to Mental Health.
18/12/2013	GP Practice	GP surgery appointment. Mental health review, discussed fax from psychiatrist stating stopped medication over a year ago, discussed lifestyle and mental health. Mental health medication removed from repeat.
28/8/2014	Safer Neighbourhood Services	Housing repair enquiry regarding disrepair – complaint from Jack's neighbour that about smoke from his solid fuel appliance in their bathroom. A housing repair officer visited the neighbour to verify the issues and then discussed with Jack who reassured that it would be rectified. The case was closed. Resolved 02/09/2014
21/10/2014	Jack's Mother's Care Home	Home Manager contacted Jack's brother because staff were concerned that Jack was giving his mother alcohol. No-one witnessed this but her nightwear was wet around the neckline and smelling of alcohol.
11/11/2014	GP practice	GP surgery appointment. Review - discussed lifestyle and mental health, given advice, not on medication. BP taken and weight, smoking cessation advice. Written notes record "abusive voices last week" and also note on no medication.
November 2014	Noise Abatement	A neighbour kept a diary of noise from Jack's property for several weeks. Issue of shouting, cursing and moving furniture at night. No action taken as not a statutory nuisance
2/12/2014	SYP	Anti social behaviour noise complaint in relation to ongoing noise issues from Jacks property
5/1/2015	ASC	The Care Home had reported that Jack tried to feed his mother bread although at this point she was on end of life care and liquids only after having a heart attack. When staff intervened, he became verbally aggressive and police were called. Following this, Jack was asked to only visit at specific times so that he could be

		supervised. Jack's younger brother was asked to address this behaviour with Jack.
10/2/2015	ASC	Jack's mother died.
13/2/2015	SYP	Anti-social behaviour noise complaint in relation to ongoing noise issues from Jack's property.
27/8/2015	SYP	Call to SYP reporting what was believed to be arguing between a male and a female. SYP attend at the house described as occupied by a woman living in the property alone. The woman advised that her neighbour Jack regularly shouts and is described by the lady as somewhat eccentric - she suggested the shouting may have been from his address.
28/1/2016	BHNFT	Attended ED following a fall. Sustained a laceration to head. Records state he was in drink on admission and was described as verbally aggressive to staff. Head wound cleaned and glued. Jack was found to have 'a pair of knives in his sock'. Self discharged from ED.
26/1/2017	ASC	DWP visiting officer contacted ASC. Concerns about living conditions, no gas, no electricity, does have running water. Cooks on open fire in bedroom. Brother struggles to contact and at times only through wrought iron gate on front door. Reported wheelbarrow, beer bottles, rotting fruit and veg in lounge, house freezing. Jack exceptionally dirty. He does go out to shop and agreed would accept support.
30/1/2017	ASC	Worker contacted brother who advised that Jack does have electricity but chooses not to use it, does not have gas, property is cold and lives as a recluse, does not bathe. Brother advised he visits weekly but does not always gain access. He supports with meals and neighbours contact him if they have concerns. Lives and cooks in bedroom. No support from GP or MH services. Potential support discussed. Visit arranged for 6/2/17.
6/2/2017	ASC	Home visit. Jack not in. Worker and brother waited to see if he returned. Whilst waiting brother informed that Jack did cook in his bedroom, but also did go out for food. Information given re meals on wheels, lifeline and services available (although brother informed Jack didn't have a phone or TV). Brother said he dealt with mail and that all

		neighbours would contact him if required. Jack did not return. Worker arranged a second visit, however brother contacted on 9/02/17 to say that Jack had declined assessment. On speaking with the brother, worker has said there was no reason to doubt Jack's capacity. Subsequently (13/2/17) case closed.
21/2/2017	SYP	Report by complainant that their cat had been stolen and had recently been seen at Jack's property. Caller advised that Jack has mental health issues. Complainant spoken to by SYP and no further action taken as complainant advises that they are happy the cat is fine having been with Jack for some time.
15/3/2017	SYP	Shotgun certificate expiry date- registered to Jack. Shotgun certificate withdrawn.
27/8/2017	SYP	Complainant reported theft of cat which had been seen at Jack's window. Complainant had previously reported a stolen cat, however hadn't pursued the matter as the cat appeared settled. The complainant had attempted to speak to Jack but he was refusing to answer the door. SYP attended, speak to Jack and a safeguarding referral is submitted as a result. Brother accompanied SYP when they attended the property and advised that his brother had severe mental health issues and would not seek help. Jack advised he had been feeding the cat but had subsequently allowed it to leave several days prior. No further action taken. Safeguarding adult referral detailed the severity of the living conditions for Jack including lack of toilet and cooking facilities, the very poor state of repair of the property, evidence of alcohol use.
4/9/2017	ASC	Safeguarding concern received from SYP. SYP attended following allegations that Jack was keeping his neighbours cats inside his property and not letting them go or caring for them. Police entered property and informed it was cluttered and unclean, alcohol bottles on floor, rotten food and foul smells. On going upstairs, faeces found in a number of buckets, flies, cobwebs and the smell was unbearable. John's bedroom was in the same state. The room contained a portable fire, used to cook food

		which appeared mouldy. All rooms cramped due to clutter, no kitchen or toilet facilities. Property in a state of disrepair, ceilings were hanging down. No facilities to cook or clean, the “pantry” was full of rotten food, jars of thick black liquid and unidentifiable rotten items hanging from the ceiling (possibly pigs ears). Discussed with MH team who agreed to screen. Request by BMBC Manager who received the concern to: contact brother; contact Housing re ownership of property; discuss with brother referral to fire service; consider VARM or refer to LTCT (decision to refer to LTCT).
5/9/2017	ASC	Worker contacted brother. Brother advised he was on holiday until 18/9/17 and would advise on return if assessment required.
19/9/2017	ASC	Brother contacted ASC and duty worker rang back. Brother advised that he would be visiting Jack the following day and will contact ASC again if a visit is required. No further contact made.
1/1/18	SYFRS	Crews called to a fire at Jack’s address. The call came in at 9.30pm from a neighbour who had called at the property earlier in the day as he had smelt smoke. Jack reported that he had lit a fire but this was now out. When crews arrived, the ground floor of the property was well alight. Information from the Fire Investigation indicates that this had been a smouldering fire, which would not have been visible to Jack as it was behind an animal cage. Jack is likely to have been overcome by carbon monoxide – he suffered burns to his leg but not his upper body. Various dead animals were found throughout the property (pig in cellar, fish, rabbits) - they were dead prior to the fire. “Thousands” of empty alcohol bottles also found in the property.
1/1/2018	YAS	999 call to a house fire. Fire and Police were at the scene. Jack was declared deceased at the scene.
1/1/2018	SYP	SYP alerted to a report of a fire at Jack’s home address at 21:38hrs. Fire service in attendance. Jack found by the fire service deceased in the bedroom. Fire deemed non-suspicious by the fire service investigating, however the occupant who lived alone in the property had been

		reported to be cooking on an open fire in his bedroom. Jack had advised neighbours earlier in the day that he had lit a fire and that part of the fireplace had caught fire but asked neighbours not to call the police since he had extinguished the fire himself. Neighbours were alerted later in the day to smoke pouring from the bedroom window of the property.

5.6 Background

5.6.1 Note: The background described below was not known in detail to agencies prior to Jack's death and is derived primarily from meeting with Jack's family during the process of this Review. It is included here by agreement with Jack's family.

5.6.2 Jack was aged 68 when he died. He was the older of two boys by four years, and had been born and spent his early life in Barnsley. His younger brother and daughter survive him. From a young age he had a difficult relationship with his father, but was in close contact with his mother until her death in 2015.

5.6.3 Jack is described as a stubborn boy who was very intelligent and did well at school. He got a place at Winchester, King Arthur College, and went on to Southampton University where he met his future wife (who herself became a teacher). His family thinks that he had four degrees – English language, English Literature, history and arts. He became a teacher of history and English and had a keen interest in politics and Russian history.

5.6.4 Following university he moved to East Finchley and worked as a school-teacher there. During this time he developed mental health issues and contacted his father, who collected him from London and took him back to Barnsley with his girlfriend. Jack and his girlfriend/ later his wife lived in Athersley and Jack taught at Royston school for two years. During this time they married and their daughter was born.

5.6.5 About three years after returning to Barnsley Jack and his wife split up and his wife took their daughter with her to live in the South of England. At this point Jack's father gave him the property he lived in until his death. From this point onwards Jack was very protective of his home and who had access to it. He would resist all visitors, though he did call and see his parents regularly, and had a close relationship with his mother who cooked meals for him and encouraged him to wash his clothes. During the early years he would see his daughter at his mother's home when she visited. She was not allowed to visit Jack at home. After his mother's death, his daughter saw Jack at his brother's house and Jack received updates on her from his brother.

5.6.6 From this point on Jack did not have any paid work but was creative, taught himself the guitar/piano, and made furniture etc. He was self-sufficient and lived a frugal life more like that of the 1920s – not using electricity, making potions to heal local animals owned by neighbours. At one stage Jack attracted the attention of "down and outs" but his brother took action to keep them away.

5.6.7 Jack was under the care of mental health services (MH) for some time and his mental health condition was variously described to his family as psychosis/psychotic depression/ schizophrenia. A document completed by his GP to exempt him from paying council tax gave the grounds as "severe mental impairment". Family

members were aware that Jack had “heard voices” and may have been suicidal at one time.

5.6.8 Prior to discharge from mental health services (2007) Jack had stopped taking his prescribed medication as he did not like the side effects, which included losing “his sharpness” and becoming lethargic and slow. Jack’s mother encouraged him in his activities of daily living and often attended appointments with him, but, following discharge from mental health services, he would only engage with medical services if he needed something, eg a sick note, help with claiming Disability Living Allowance. He seemed to be physically well though unkempt in appearance. He is described as uncomfortable with people, especially those he didn't know, and contact with him was only on his terms, as he didn't like people prying into his affairs.

5.6.9 Jack told his family that he had stopped drinking after the incident in a shop (2013) where police were involved, saying it was a “mug’s game”. However, “loads of bottles” were cleared from his house after this death.

5.6.10 Jack’s relationship with his mother increased after the death of his father. When she developed dementia, Jack’s brother would visit daily and cook for both mother and Jack. When mother went into a nursing home, as her needs could not be met at home, Jack did not have any contact with her for six months. After this he sometimes visited at inappropriate times (eg early morning) and took whisky to the Home for her.

5.6.11 Jack took the death of his mother very badly and stopped going to church. He was angry that a woman minister had conducted the funeral service (the minister had been a close friend of his mother).

5.6.12 His brother would visit him on the same day at the same time each week and take food. Despite this his brother was often unable to access the house, although sometimes Jack would ask him to fetch things, eg logs. Often Jack was rude to his brother, but would later apologise.

5.6.13 Jack is described as “well liked” by the neighbours who kept an eye out for him. A long-standing next door neighbour would knock on the wall if he hadn’t seen or heard Jack, and neighbours would contact his brother if worried about him. The neighbours knew that Jack fed and treated local animals and would check if animals were with him if they went missing. This resulted in the police being involved over a stolen cat (2017). Following this, his brother bought Jack a cat and had it inoculated and spayed etc. The cat and 3 rabbits perished in the house fire. Jack also kept in touch with an old friend whom he met regularly at the local conservative club.

5.6.14 During his last year Jack asked his brother for a radio, microwave and black electric kettle. After his death the microwave and kettle were found still in boxes. He used the radio to listen to Classic FM. His brother would take photos of Jack’s daughter and her children to show him, although they did not see him, despite visiting Barnsley every few years and staying with family members. Jack would

contact his brother if he needed help to sort out benefits or other issues, and had been persuaded to take out funeral cover. He also had money in the bank but died without having made a Will.

5.6.15 Jack used his bedroom as living space as it had a fire and a grate where he could cook food.

5.6.16 A number of the neighbours attended Jack's funeral, and his daughter travelled over to attend from America.

5.6.17 After Jack's death it took three 10 tonne skips, protective clothing, and gallons of cleaning fluid to clean the house. There were barrels of salted pork and hung gammons in the cellar, which family members understood as a throwback to Jack's childhood, growing up with a father who was a butcher. The family also found many containers of stored faeces and felt that Jack would have been embarrassed if people had seen the state of his home.

5.6.18 A key family comment about Jack was: "it was Jack's way or no way."

6. Analysis of individual case

6.1 Chronological Analysis

6.1.1 Jack was a man who developed mental health problems early in life and is regarded by family as having lived with mental health problems over the years since then.

6.1.2 He was an intelligent, strong-minded, independent and private man and this coloured his contact with services.

6.1.3 2003-2007

Over this period Jack was seen by local mental health services, and on referral to them was described as "in a neglected state" and had been hearing voices for "five years plus". This suggests that a degree of self-neglect was long standing and well established. The mental health diagnosis recorded in the GP records was schizoaffective disorder and there are references to depressive episodes and treatment with both anti-psychotic drugs and anti-depressive drugs.

In 2004 when he had an OT assessment at his home, the OT noted his basic living conditions:

- Few modern facilities
- No central heating
- No running water
- Cooker not connected
- Using an open fire "when necessary"

The OT also noted that his mother played a major role in supporting him and the records show that she attended out-patient appointments with him and "enjoyed doing his cooking and … laundry". From Jack's family we know that his mother could be assertive with Jack and tell him what to do, for example, to change his clothes and leave them with her for washing.

At the end of this period, in 2007 Jack was discharged back to his GP, who knew him well, at a time that his mental state was "stable".

Key points over this period include:

- Reference to self-neglect
- Established long-term mental health problems
- Basic living conditions in Jack's home
- The important role of his mother

6.1.4 December 2010-February 2015

This period started with Jack's mother being referred to ASC for assessment and practical help. We understand that she had developed dementia. She moved into a Care Home in July 2012 and over this time her ability to support

Jack must have declined and eventually ceased. Jack's brother became drawn in to support both their mother and his brother.

In December 2013 an adult concern referral (CID70) was initiated by SYP after an incident in the town centre involving the theft of whisky. At this stage the GP reviewed Jack's mental health and learned that he had stopped his medication over a year previously.

The following year (2014) there was a report that smoke from a wood-burning stove was entering a neighbouring property and it seems likely that the stove was not repaired, rather that Jack stopped using it.

Two other areas of concern became apparent. One was alcohol: the manager of the Home where Jack's mother lived contacted his brother to express staff concern that Jack was giving his mother alcohol. The second was noise from Jack's property, described as "shouting, cursing and moving furniture at night". There has to be a strong suspicion that the noise was related to psychotic experiences, probably hallucinations, since we know that Jack lived alone.

This period ends with Jack's mother's death in February 2015.
Key points over this period include:

- The loss of support from his Mother and her eventual death
- References to alcohol
- Suspicions that he was having psychotic experiences
- Suggestions of further deterioration in the state of Jack's home
- The first adult concern referral (CID70) in December 2013 – this was followed by an assessment by a GP.

6.1.5 February 2015- January 2018

After Jack's mother died his main support fell to his brother but Jack was increasingly reclusive: he controlled his brother's access to the house and restricted his contact with him. There were ongoing noise issues and, although Jack told his brother that he had stopped drinking, he attended the local ED with a head wound when he was "in drink" in 2016 and was found to have "a pair of knives in his sock".

A second referral was made in January 2017, this time to ASC by a DWP officer concerned about Jack's living conditions:

- No gas
- No electricity
- Cooking on open fire in bedroom
- House "freezing"
- Rotting food in house
- Neglect of personal hygiene

This referral was followed by a home visit but unfortunately Jack was not in. Information at the time showed that Jack's brother was an important support for him but that he could not always get in. A second visit was arranged but

Jack's brother contacted the worker to say that Jack did not want to be assessed, so it was cancelled and the case was closed.

Around the same time (February 2017) a complainant reported their cat stolen to SYP, saying that the cat had been seen at Jack's property. There was a second complaint of a stolen cat later that year in August, and the Police spoke to Jack at his home on this occasion. Subsequently they made a safeguarding referral (September 2017). This safeguarding referral detailed Jack's poor living conditions, including:

- Cluttered and unclean
- Rotten food, mouldy food
- Foul smells
- Faeces in buckets
- No kitchen or toilet facilities
- Disrepair, ceilings hanging down
- Alcohol bottles
- Portable fire in bedroom used to cook food

Jack's brother told officers that his brother had severe mental health issues and ASC discussed the referral with the MH team who agreed to screen. Other options considered at this stage included referral to Fire and Rescue, Vulnerable Adult Risk Management, and referral to the Long Term Care Team. A worker contacted Jack's brother who said that he would advise on his return from holiday if assessment was required: he later rang back and said he would visit Jack and contact ASC again if a visit was required.

This period ends with a house fire at Jack's address and Jack was found dead in the bedroom.

Key points over this period include:

- Ongoing noise issues
- Ongoing suspicion of alcohol use
- Referral to ASC by a DWP officer concerned about Jack's living conditions – a missed opportunity to assess/ intervene
- The Police adult concern referral (CID70) in September 2017 detailing Jack's poor living conditions – another missed opportunity to assess/ intervene
- Brother's experience (as told to SYP) was that Jack would not accept help and he took on the responsibility of respecting what he understood to be Jack's wishes

6.1.6 It is evident from the chronological analysis that no single agency had knowledge of all the issues.

6.2 Thematic analysis

6.2.1 Self-neglect and capacity

Self-neglect is included in the Care Act 2014 categories of abuse or neglect relevant to safeguarding adults with care and support needs. It often presents a complex challenging human rights issue for practitioners because of the need to balance respect for an individual's autonomy with the practitioner's duty of care requiring them to protect that adult's health and wellbeing. There is no agreed and accepted definition of self-neglect[8]. Barnsley's Multi-Agency Self-Neglect and Hoarding Policy and Procedure provides some useful contextual information and highlights three areas that may be regarded as characteristic of self-neglect: these are

- Lack of self-care
- Lack of care of one's environment
- Refusal of assistance that might alleviate these issues.

There was evidence that Jack was neglecting both his self-care and his home environment, and had refused or resisted assistance with these issues through his brother as intermediary. It is generally accepted that interagency communication, collaboration and risk-sharing are core to working with people who self-neglect.

Capacity is a tricky issue. Is this individual making a choice to live in this situation? It can be easier to work with a person who lacks capacity to make key decisions about their living circumstances, as the Mental Capacity Act (2005) then comes into effect and provides a statutory framework for making decisions on that person's behalf. When a person poses a serious risk to their health and safety as a result of self-neglect, this may call into question their capacity to make key decisions about their living circumstances, and, if that is the case, then a capacity assessment will be indicated. Jack's capacity was assumed on the basis of information given by his brother and was not assessed. Interventions (when a person has capacity at the time for the necessary decisions) will need to be with that person's consent and achieving a working relationship with such an individual may require considerable tenacity, persistence and work in order to develop a one-to-one relationship with them, except in circumstances when statutory powers come into play.

Missed potential opportunities to involve partners

There were missed potential opportunities to further assess or intervene with Jack, namely:

- The review by the GP in November 2014
- The DWP officer referral to ASC in January 2017 when self-neglect was becoming evident
- The second safeguarding referral[8] by SYP in September 2017 which gave details of the severity of Jack's living conditions

[8] For fuller discussion of these issues see Braye, Orr & Preston-Shoot (2011) Self-neglect and adult safeguarding: findings from research, available at https://www.scie.org.uk/publications/reports/report46.pdf

The first Police safeguarding concern was followed by his GP reviewing Jack's mental health in December 2013 and, on the balance of probabilities, it appears that this was a response to the concern, although there is no clear documentation to support this. The GP review was likely to be a proportionate response at that stage, given the information available and the fact that the safeguarding threshold was not met. GP learned that Jack was not taking his psychiatric medications at this stage, and, when Jack was reviewed approximately 12 months later, "abusive voices last week" were noted. The GP did not see Jack again after this last contact. We understand that the practice involved in Jack's care has recently changed their system for dealing with people who fail to attend. If the non-attenders are on medication or on the severe mental illness register they will receive three letters and if they fail to respond to the letters a GP will review and consider what action if any to take.

The second opportunity led to no further action as Jack's brother told the ASC worker that Jack had "declined assessment" and the worker assumed that Jack had capacity on the basis of the brother's account. See comments on difficulties for family below.

The third opportunity again led to no further action. Once more Jack's brother was put in the position of mediating between his brother and ASC and of taking responsibility to decide whether further visits to see Jack should be undertaken.

The second and third referrals were missed opportunities to involve other agencies.

Difficulties for family

Families who have a member with long-standing mental health problems may have a long history of seeing their family member decline services, setting up an expectation in the relative that nothing can be done – which may indeed be correct on many occasions. Family members, like the person concerned, may have limited knowledge of available options: they may not understand what the possibilities are. They may also develop a level of tolerance by getting used to some problems over time. Discussions between family members and a relative with a long-standing illness will be influenced by relationships and expectations. It is striking that Jack's mother had the authority to insist that Jack should comply with some of her expectations. This was an authority that his brother did not carry, despite the fact that he assumed some responsibilities for his brother after their mother's death. Often people much prefer a relative to do things for them rather than a stranger, and this puts pressure on both parties involved. It is not uncommon for one family member to decline services on behalf of another family member, when their experience and/ or belief is that the other family member will not accept services after years of seeing their ill relative decline help.

The advantage of a worker coming in from outside (apart from the skills they bring to the encounter) is that they do not share this long history of failing to

influence the situation and can bring a new perspective to the situation by respectfully acknowledging the relative's views but at the same time saying firmly that they need to hear the views of the person concerned first hand.

The role of family members as carers is another area of difficulty, as family members may not see themselves as carers. Jack's mother could have been recognised as his carer as she was supporting him in a number of ways and his situation appears to have deteriorated once she became unable to continue her input. Jack's brother became his carer after their mother was unable to continue. It appears that neither was offered a carers assessment. Would a carers assessment have made a difference? If Jack's mother's role had been acknowledged then the effect of her illness and move into a Care Home might have been anticipated to some extent.

Recognising and sharing risk

SYP use the Vulnerability Assessment Framework (VAF) as part of their mental health toolkit and this provides a simple and memorable structure for looking at vulnerability and communicating key observations to partner agencies. The VAF was launched as part of the Mental Health toolkit in March 2018 and is available to support all staff and officers when dealing with individuals who are experiencing mental health issues. Self-neglect was noted early in the chronology when Jack presented to mental health services in 2003 and it is likely that it worsened particularly after Jack's mother became unable to support him and subsequently died. When change occurs gradually those around the person may become used to the difficulties and used to accepting them as part of life. It also becomes difficult to know when those changes come to involve risk to self or others. New eyes looking at the situation give the opportunity for a new assessment: thus the DWP officer coming into the situation was concerned about Jack's living circumstances, as were the police officers who talked to Jack after a cat was reported stolen. Having recognised risk, then a mechanism to communicate severity and urgency is needed so that partner agencies can prioritise the situation.

The learning event flagged up the assumption that it is sufficient to make a single referral (eg to ASC) and expect that agency to involve others. If the key to working with self-neglecting individuals is collaboration and partnership working then involving partners at an early stage is likely to be better practice.

Documentation and record-keeping

Discussions in the learning event and the reference group highlighted the fact that the two referrals from SYP to ASC in December 2013 and September 2017 were both regarded by the Police as safeguarding referrals and were submitted on the same Adult Concern Form (CID70). From the ASC perspective Concerns submitted on form CID70 are not necessarily received as safeguarding referrals and there is flexibility over whether ASC regards a Concern as a referral for safeguarding or for support. This is an area where clarity would be helpful to all concerned so that both referring and receiving agencies are clear whether a referral is for safeguarding or for support, and a

referral for support needs to be accompanied by consent, unless the person lacks capacity to give informed consent.

A second record-keeping issue was highlighted by difficulty in tracking how mental health services responded on two occasions.

The first occasion was when ASC passed Jack's case to the Central CMHT in December 2013. Mental health services fed back to the reference group that they could not find a record of this referral, but the GP records show that a GP surgery appointment for mental health review took place after the surgery received a fax from a psychiatrist. On the balance of probability, it seems reasonable to assume that this was in response to the case being passed to the Central CMHT.

The second occasion was in September 2017 when ASC discussed Jack with the mental health team who agreed to "screen". The SPA team manager was found to have a copy of the Police referral form and an email response to ASC, but it appears that this email was not received by ASC who were unaware that the advice from mental health was to contact housing in view of the fact that there was no consent to mental health involvement.

These two incidents flag up a need to close the loop so that a referring agency is aware of whether (and what) action results from a referral and is able to follow up if no feedback is received.

6.6 Examples of good practice

We have identified eight examples of good practice in the course of this SAR.

6.6.1 The recognition of self-neglect and hoarding evident in the safeguarding referral submitted in September 2017 by SYP is evidence of good practice that could be replicated across SYP through effective training. In addition, the professional curiosity and resilience demonstrated by the officers attending resulted in them gaining access to the property having tried persistently for over an hour. Professional curiosity combined with accurate checking of SYP records will assist officers in their decision-making in relation to the Safeguarding of Adults at Risk.

6.6.2 The Chair/ Author of this SAR was impressed by the fact that IMRs were returned on time – this has not been her usual experience.

6.6.3 ASC Senior Managers had already undertaken an internal review of this case and shared their findings with staff through staff briefings. This is important in disseminating learning without delay.

6.6.4 The change in how the GP practice involved in Jack's care deals with people who fail to attend is another example of good practice. If non-attenders are on medication or on the severe mental illness register they will receive three letters and if they fail to respond to the letters a GP will review and consider what action if any to take.

6.6.5 The VAF used by SYP is an example of good practice. It was launched as part of the wider vulnerability agenda in March 2018 and is available to support all staff and officers when dealing with individuals who are identified as being vulnerable including those with mental health issues.

6.6.6 The new Barnsley Multi-Agency Self-Neglect and Hoarding Policy and the tools within it are an example of good practice and training is an opportunity to cascade its use in order to make sure that it is used.

6.6.7 ASC has changed its structure/ teams to try to minimise customer hand-offs.

6.6.8 The Safer Neighbourhood Services set up in its current structure and partnership arrangements since 2016 and has developed a formal partnership operating process that determines the appropriate level of service at the point of entry via triage and assessment. This should facilitate identification of possible mental health issues and appropriate referral to partner agencies.

7. Conclusions & recommendations

7.1 Lessons Learned

Missed opportunities to involve other relevant agencies
The lessons learned from the missed opportunities to involve other relevant agencies are:

- Not to rely on a single referral. Instead if other agencies could usefully be involved refer to them at the same time rather than relying on a partner to make the referrals.
- Thus instead of relying on ASC to refer Jack on to other agencies, Fire and Rescue could have been involved at an earlier stage and perhaps primary care.
- Consent should be sought for all referrals except where there is a safeguarding concern, the person lacks capacity, they are acting under duress, or action needs to be taken to protect others.
- Ensure that the urgency of the situation is communicated. Tools within the Barnsley Multi-Agency Self-Neglect and Hoarding Policy and Procedure enable the degree of self-neglect to be assessed, rated and communicated and also give guidance on involving partner agencies. Embedding the use of this policy and the tools included within it will support multi-agency partners in working with complex self-neglect.

Working with complex cases of self-neglect

- With current pressure on services there is a risk that people who are reclusive and reluctant to engage will be over-looked by services.
- Sometimes there might be a belief that an individual is making life choices and that lifestyle as a choice may be given priority over vulnerability and risk. This decision cannot be made on third party information (see over-reliance on brother below).
- There is an argument that an identified worker should be enabled to develop a relationship with people in situations of severe and complex self-neglect. This will involve tenacity and persistence, accepting that they will not always be able to gain entry to premises and to see the person concerned but that time needs to be spent on developing a relationship in order to be able to intervene.
- Management sign-up is needed to support practitioners in long-term work with complex cases.
- Alongside this there may be a need for joint agency visits for people who are difficult to engage and for vulnerable adult risk management meetings.
- How do agencies decide when risk to others over-rides decisions made by a capacitated self-neglecting person?
- How do agencies ensure that information is shared with partners?

“Over-reliance on brother”

- Jack’s brother acted as an intermediary in reporting to services that he did not want services/ assessment (February and September 2017). Decisions should have been made by Jack, in conjunction with staff

from ASC, provided Jack had capacity at the time for the decisions that needed to be made. Family members may not themselves have access to all the information that someone requires to make a decision, they may have an expectation that an individual will refuse services and that nothing can be done, and in addition the relationship between family members may influence whether or not an individual agrees to intervention/ assessment or not. Decisions transmitted by Jack's brother were taken at face value and, as a result, Jack was not seen and assessed. It must also be acknowledged that there are some cases when family members may not be acting in the interests of their relative.

- This placed a lot of responsibility on Jack's brother despite the fact he was never offered a carers assessment (and nor was Jack's mother who was Jack's carer before his brother became involved).
- Jack's capacity was assumed and not assessed despite the fact that he was living in circumstances that might be seen by others as calling his capacity to make choices about his living situation into question.

Use of available powers

- Concerns by Police and DWP officer could have prompted exploration of potential use of environmental health powers.
- Available powers are included within the Barnsley Multi-Agency Self-Neglect and Hoarding Policy and flagged up in training on its use.

Mental health (MH) and primary care

- The lessons learned meeting flagged up the importance of language eg the distinction between not known to MH services and not currently open to MH services. Use of "not currently open to MH services" would encourage dialogue relating to any historical involvement.
- The GP records should include comprehensive information in respect of an individual's MH history. How might this information be more easily accessed by and shared with partner agencies?
- GPs could be contacted for further information and informed where there are relevant concerns.
- Responses to people who don't attend in general practice and are known to have long-standing mental illness.

Closing the loop – feedback on referrals

- The outcome of referrals was not fed back to the referring agency on several occasions. Good practice would be to feed back what has happened in response to the referral - how can the loop be closed?

Training issues

- Cascading the new Barnsley Multi-Agency Self-Neglect and Hoarding Policy to practitioners and training in its use.
- Environmental health/ public health powers
- Awareness of the role of Fire & Rescue Services.

7.2 Recommendations

The single agency recommendations listed below (under paragraphs 7.2.1-7.2.4) were taken from IMRs or developed during discussions. Multi-agency recommendations are listed under paragraph 7.2.5.

NOTE: numbering of all recommendations below is cumulative.

7.2.1 Barnsley Adult Social Care

1. ASC defensible documentation/record keeping
ASC case recording will meet the expected standards for professional recording (timely, complete, concise, factual, objective, professional) and will provide a clear rationale for professional decision making.

2. Defensible SW practice, managerial oversight & decision support
ASC Adult Safeguarding practice will adhere to the principles of Making Safeguarding Personal, the Mental Capacity Act, the wider public interest, alongside good social work practice of professional curiosity and tenacity.

There will be appropriate managerial oversight and support for SW decision making.

3. Joint/collaborative working & communication
ASC will maintain effective communication and work collaboratively with partner agencies in respect of safeguarding adults.

7.2.2 GP Surgery

4. Dealing with Non-attendance
The GP practice has developed a new system and supporting processes to identify the need for a review of repeat non-attendance at appointments by a senior clinician.
Information about this new system will be shared with all GP practices in Barnsley as an example of good practice.

7.2.3 SWYPFT

5. Documentation/ record keeping
To ensure that there is clear documentation and system of recording the communication between SWYPFT and other partner agencies in relation to safeguarding referrals.

7.2.4 South Yorkshire Police (SYP)

6. Guidance on and use of referral route into SYFAR
Local referral units to be provided guidance and ensure referrals to South Yorkshire Fire and Rescue are made where concerns are identified via Safeguarding Adult Referrals

All staff to be made aware of referrals to SYFAR via training and use of internal intranet article.

7.2.5 Multi-agency Recommendations

These recommendations derived from discussions at the Learning event and following meetings focussed on how agencies might better work together and, in particular, how to ensure training in the use of the Barnsley Multi-Agency Self-Neglect and Hoarding Policy and Procedure and the tools included within it, and how to embed the use of the Barnsley Multi-Agency Self-Neglect and Hoarding Policy and Procedure and the tools included within it in practice.

The Barnsley Multi-Agency Self-Neglect and Hoarding Policy states that:

The most effective approaches are likely to be consensual and non-statutory and to be based on a long-term approach that involves developing a relationship with the person who self-neglects and/or hoards; sensitively raising the problems their behaviour causes for them or for others; working with them to find solutions and providing assistance to put these into action. Interventions may include de-cluttering or cleaning, although this is likely to be temporary unless made in the context of shaping the person's behaviour.

These multi-agency recommendations are included to strengthen use of the Policy.

7. Use of the Barnsley Multi-Agency Self-Neglect and Hoarding Policy
Ensure that all staff within partner agencies understand the Barnsley Multi-Agency Self-Neglect and Hoarding Policy and encourage use of the risk tools for both self neglect and hoarding in the policy before sending in a safeguarding referral and to be able to evidence that single agency working has not impacted on the risks. Understanding and use of the Policy will need to be addressed in both training and supervision.

Embed the use of this Policy into normal daily practice to ensure that this is reviewed against all relevant cases especially or the most complex ones discussed at the multi-agency hub panel.

8. Safeguarding Practice
Ensure that partner agency employees' knowledge is systematically refreshed in terms of how to escalate concerns and where to send relevant alerts, supported and where appropriate include powers that Environmental health have in these circumstances.

9. Agency support for long term working with high risk individuals
The Independent Author recommends that agencies consider how the system might ensure that an identified practitioner is in a position to develop a trusting relationship over time with someone in a complex self-neglect situation with a high level of risk.

10. Learning Brief: carers, capacity and involvement of family in decision-making

The Safeguarding Adults Board will produce a learning brief, which will be widely disseminated in partner agencies, and address key points including:

- Identification/ recognition of carers who do not self-identify as such
- Involvement of family in decision-making. The independent author identified that there was an over reliance on the brother to act as an intermediary in reporting to systems that he (the Adult) did not want services / assessment.
- Capacity. The independent author identified that capacity was never assessed, it was assumed. The learning in relation to whether the adult was '*making life choices and that lifestyle should take priority over vulnerability and risk'* needs to be disseminated to partner agencies and included in training.

Glossary of abbreviations

ASB or SAB	Adult Safeguarding Board or Safeguarding Adults Board
ASC	Adult Social Care, Barnsley
BMBC	Barnsley Metropolitan Borough Council
CCG	Clinical Commissioning Group
CID	Criminal Investigation Department
CMHT	Community Mental Health Team
DHR	Domestic Homicide Review
DLA	Disability Living Allowance
DWP	Department of Work and Pensions
ED	Emergency Department
GP	General practitioner or General Practice
IMR	Individual Management Review
LTCT	Long Term Care Team
MCA	Mental Capacity Act 2005
MH	Mental Health
NHS	National Health Service
OT	Occupational Therapist or Occupational Therapy
SAB or ASB	Safeguarding Adults Board or Adult Safeguarding Board
SAR	Safeguarding Adult Review
SW	Social Work/ Social Worker
SWYPFT	South West Yorkshire Partnership Foundation NHS Trust
SYFAR	South Yorkshire Fire and Rescue
SYP	South Yorkshire Police
TV	Television
VARM	Vulnerable Adult Risk Management
VAF	Vulnerable Adult Framework