Lessons Learned Research Digest

Issue 1 November 2019

Welcome to the first edition of the Darlington Safeguarding Partnership Research Digest bulletin. The bulletin has been produced to share messages from recently published Child Safeguarding Practice Reviews/Safeguarding Adults Reviews /Lessons Learned Reviews and any local lessons learned. The cases identify lessons to be learned to improve learning and develop practice across multi-agencies to safeguard children and young people and adults with needs for care and support.

This bulletin focuses on reviews published in 2018/2019.

learning.nspcc.org.uk/case-reviews/recently-published-case-reviews

In addition, the NSPCC provides a thematic briefing highlighting the learning from SCR's which focuses on the different topics.

www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/

Local Learning

CASE	LEARNING

Regional Learning

CASE	Report
February 2018 - Newcastle -upon-Tyne Joint Serious Case Review Concerning the Sexual Exploitation of Children and Adults	Joint Serious Case Review Concerning Sexual Exploitation of Children and Adults with Needs for Care and Support in Newcastle-upon-Tyne In February 2018 the Newcastle Safeguarding Adults Board (NSAB) and the Newcastle Safeguarding Children Board (NSCB) published a Joint Serious Case Review to consider and learn from sexual exploitation involving children and young adults in Newcastle. The Joint Serious Case Review fulfils the NSAB's duty under the Care Act (2014) to undertake Safeguarding Adults Reviews. The report contains a number of local and national recommendations. Some of the key learning points which have already been carefully considered include: • the complex nature of sexual exploitation • the extreme and long lasting impact it has on victims • that sexual exploitation happens to adults as well as children • and difficulties in identifying and preventing exploitation.

	Working with victims has reinforced the importance of intense and long-term support required to gain their trust and also to help them understand their experience and so enable them to talk about this. The primary aim has and continues to be to support and protect victims from further exploitation and to help them so far as possible to rebuild positive lives.

Reviews undertaken by the National Panel

THEME	LEARNING
Adolescents at risk of criminal exploitation	Report due for publication before end of December 2019. Review involves, 21 cases around the country ,10 from London, all males who have died or suffered significant injury.

National Learning

PHYSICAL AND EMOTIONAL ABUSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2019- Anonymous-John Physical abuse to a child with disability who was not independently mobile and was pre verbal	Multiple unexplained injuries to a disabled 2-year-6-month-old boy between October and December 2016. John suffered serious significant leg fractures more than once, with X-rays showing healing rib fractures; he was a child with disabilities who was not independently mobile and was pre-verbal. Overview Report	**Learning:** • John's disability needs were a distraction leading to a lack of focus on the vulnerabilities/risks to John following domestic abuse incidents • where there is suspicion of a potential non-accidental injury a formal Child Protection Medical should be undertaken to assess risk and inform decision-making

		• the response to the third incident of domestic abuse was not robust and left John and siblings at risk of harm • the Child in Need plan was not child focused. **Recommendations:** • to seek assurance that the multi-agency response to domestic abuse is in line with its policies and procedures • to assure itself that the daily lived experience of children is central and captured in all the work partners undertake to promote their health and wellbeing.
2019 - Tower Hamlets - Baby Adam Bruising first reported on a 6-week-old boy in March 2016, with further bruising and fractures documented over the next month and six days	Bruising first reported on a 6-week-old boy in March 2016, with further bruising and fractures documented over the next month and six days. Mother had planned a home birth but due to complications Baby Adam was born by emergency caesarean section. At first new birth visit when Adam was 12 days old, parents described how they had been traumatised by the birth; health visitor referred sibling Isaac, a 3-year-old, for assessment as he was still in nappies and not talking. Father was main carer of Isaac as mother worked; he had been in long-term unemployment due to severe chronic ill health. Adam was admitted to hospital three times for unexplained bruising; blood tests and x-rays were carried out to rule out a medical condition. Family of Asian descent. <u>Overview report</u>	L**earning:** • A hierarchical approach in the working environment leads to professional deference and makes challenging medical professionals and decisions difficult • child protection practice requires collaborative work and professional respect • needs of fathers must be properly assessed and engaged; change to modern service delivery models cannot guarantee continuity of care • service thresholds were applied that did not correspond to the needs described R**ecommendations:** • all agencies must undertake a review of internal and inter-agency information sharing systems including use of electronic recording, flagging and coding systems

		• community health visiting and children's social care services must incorporate a 'think family approach' as standard • the LSCB must develop and agree a protocol for responding to bruising in pre-mobile babies and disabled children who are dependent and unable to communicate.
2019 - Croydon- Child A and Baby N Death of a two and a half week old boy in March 2016 due to a non-accidental head injury	Death of a 2-and-a-half-week-old boy in March 2016 due to a non-accidental head injury. Baby N was admitted to hospital having suffered a subdural haemorrhage and cardiac arrest. Police investigation commenced once post mortem indicated that Baby N's death was suspicious. Prior to his death Baby N's sibling, Child A, a 21-month-old girl, had presented at hospital on two occasions with head injuries and was admitted on one occasion but child protection procedures were not commenced. Child A became the subject of care proceedings after police investigation. Crown Prosecution Service decided not to initiate a criminal prosecution in November 2018. Information sharing; record keeping; compliance with child protection procedures; professional curiosity and the role of fathers. Mother is white European; father of Child A is black British/African; father of Baby N is black British/Caribbean. Overview report	**Learning:** • agencies need to ensure that they record full details of both the baby's father and all members of the household • Children's Services need to ensure that they have understood medical information and not be entirely led by medical opinion • professionals in MASH need to discuss and evaluate information not just share it. **Recommendations:** • ensure the participation of agencies in serious case reviews, both in relation to attendance at meetings and responding to requests for information • findings of research into head injuries in children to be included in inter-agency training • seek assurances from partner agencies that managers are equipped with the skills and knowledge to provide effective oversight of child protection cases.

NEGLECT		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2019- Lincolnshire LSCB- Neglect of four siblings	Neglect of four siblings over a period of several years. Matthew admitted to hospital with a non-accidental head injury in November 2016, diagnosed as a fractured skull. Lincolnshire police investigated but case has now closed. Mother known to children's social care since 1997. Mother had a history of heroin use and offending behaviour. Several referrals to Children's Social Care from 2006-2013 related to parental drug misuse and family violence. Catherine taken to A&E for bumps and bruises believed to be related to poor parental supervision. Concerns about mother's heroin use whilst pregnant with Andrew. Twins born prematurely and diagnosed with Neo Natal Abstinence Syndrome. All siblings subject of child protection plans, stepped down to Children in Need in June 2016. Ethnicity of the family not specified. Overview Report	L**earning:** • when professionals do not have an understanding of the family history, relationships and functioning it is difficult to have a clear picture about what daily life is like for the children • significant decisions should be informed through key assessments being completed, including pre-birth parenting assessment and risk assessments. **Recommendations:** • seek assurance that the model used in assessing risk within conferences is being used effectively • seek assurance in the practice of Independent Child Protection Chairs and their management of conferences • consider establishing a practice by which CP plans should not be removed at the first review unless there are evidenced circumstances • seek assurance that the professional resolution and escalation procedure is understood and effectively applied in all partner organisations.
Hertfordshire Safeguarding Children Board – Child I Death of an infant boy under 1-year-old in April 2017 due to drowning.	Child I was left unattended whilst bathing with his sibling (IS). IS and unborn sibling subsequently made subjects of a child protection plan. No criminal charges were brought. Police described home conditions as neglectful. Mother (IM) and father (IF) both asylum seekers to the UK from	L**earning:** • Housing providers may have indications that families with young children are struggling and may benefit from support • family might have benefited if greater consideration was given to social factors

	Southern Africa. IM had previously been admitted to hospital and detained by police under the Mental Health Act. IM had three unsuccessful pregnancies between March 2013 and April 2014. IF was known to police for domestic abuse and disclosed to GP he was suffering from stress at work; later lost his job. Mother and father are of black African heritage. <u>Overview report</u>	including ethnicity, apparent isolation, historical mental health concerns and status as asylum seekers • ensure good communication between GP and maternity services, sharing information on previous parental mental health and details of previous pregnancy complications. **Recommendations:** • seek assurance from health providers that social and medical risk factors in pregnant women are communicated to maternity services by GPs • seek assurance from the police that when responding to domestic abuse all relevant information is shared with partner agencies • seek assurances from housing commissioners that staff making home visits receive suitable training in recognising and responding to concerns about vulnerable adults and children.

SUDDEN UNEXPECTED DEATHS IN INFANTS AND CHILDREN		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2018- Anonymous – Baby L Death of a 3-month-old baby in 2016. An inquest recorded a verdict of death by natural causes.	Death of a three-month-old baby in 2016. An inquest recorded a verdict of death by natural causes. There were indications of drug use, poor home conditions and neglect within the family which included four other children. Children's services had been involved with the family at	**Learning:** • partner agencies' concerns were often not accepted by children's social care • families do not fully understand the differences between Level 2, Level 3 and Child in Need within the Common Assessment Framework

	various times over several years. The mother was arrested and a criminal investigation initiated. <u>Overview report</u>	• lack of openness within children's social care to escalate cases • uncertainty as to the appropriate response when the mother refused access to the health visitor and other workers • no consideration given as to why the mother was neglectful or what levels of support she had in the community. **Recommendations:** • the need to develop a broader agreement amongst partner agencies on the application of thresholds • to review the effectiveness of the escalation policy and its application locally • children's services should develop clear practice guidance on the use of announced and unannounced visits • professionals leading on a Level 3 Common Assessment Framework (CAF) should ensure that GPs are fully informed of CAF activity in line with existing procedures.

SEXUAL ABUSE and CSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2018 – Anonymous – Katie Sexual Exploitation of a 14 year old girl from September 2016-March 2018	Sexual exploitation of a 14-year-old girl from September 2016 to March 2018. Katie lived with her mother, step-father and their children. Family known to Family Support Service and children's services. Katie lived with her father	**Learning:** • use of language by some practitioners from a range of agencies in a number of settings to describe typical behaviours of young people experiencing child sexual

	briefly before moving to foster care. She had a history of going missing, smoking and taking drugs and first disclosed sexual activity with an older male in September 2016. Ethnicity of the family not specified. Overview report	exploitation (CSE) suggest understanding the dynamics of CSE requires a step change • impact of neglect and emotional abuse on adolescents is often underestimated more robust connections need to be made between CSE and other forms of criminal exploitation, e.g. drug use • taking personal and professional responsibility to ensure the system is working for every child. **Recommendations:** • to ensure that there is a 'golden thread' that links strategy, policy and practice and that practitioners are competent in working with children who are potentially or actually victims of CSE • consider the value of applying a 'contextual safeguarding' approach to safeguarding adolescents taking into account the influence of peers, school and community • check that practitioners understand their responsibilities to relentlessly pursue any concerns that the system is not working for the child.
2019- Anonymous- Patrick and Patricia Sexual Abuse of two half siblings aged 10 and 6 years and the drift and delay in planning for their future	Concerns about the risk of sexual abuse of two half-siblings aged 10 and nearly 6 years old, and about the drift and delay in planning for their future. Overview report	**Learning**: • there is a difference between the risk of reoffending and the risk of harm that a convicted sex offender might pose to a child in their family • the need for social workers to understand other agencies' risk assessments

		• the importance of keeping historic 'risk' alive • the importance of pre-birth assessments and child protection conferences • the effectiveness of step-down and escalation. **Recommendations**: • amend Child Protection procedures to state that when a child is subject to a child protection plan and a parent or carer is on the sex offender register, their sex offender manager should be a part of the core group • when children's names are on a Child Protection plan and there are concerns about possible sexual abuse, risk of sexual abuse is the most appropriate category.
2019- Anonymous Sexual Abuse by a Local Authority Foster Carer	Sexual abuse of eight primary school aged children by an approved local authority foster carer. The foster carer was a man in his 50s who, along with his wife, had fostered more than 30 children, placed by the local authority since their approval in 2001. <u>Overview report</u>	**Learning:** • lack of rigour and thoroughness in assessment and approval process in recruitment and approval of prospective foster carers • arrangements for placement of children was above the approved level and outside the approved age range • shortcomings in procedures and practice make looked after children more vulnerable to abuse and less likely to report it. **Recommendations:** • to apply standards of good practice to all aspects of recruitment of foster carers • foster care placements must be made as far as possible with carers who have

		been assessed as able to meet their needs; that systems for granting exemptions to the approved number of children placed in a foster home operate in line with fostering regulations • provide assurance that arrangements for supervision and oversight of the work of foster carers are effective.

BEHAVIOURAL/MENTAL HEALTH CONCERNS		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2019 - City and Hackney LSCB – Rachel Death by suicide of a 16 year old girl	Death by suicide of a 16-year-3-month-old girl in January 2017. Rachel lived with her mother and younger sister; she had frequent support from her father and his partner. Her family, school and local Child and Adolescent Mental Health Services had been concerned about her wellbeing for some time including a risk of self-harm, suicidal ideation and acts. She became known to her GP, the local Emergency Department, ambulance services, police and children's social care. The family is White British. <u>Overview report</u>	**Learning:** • the reliability of a young person taking prescribed medications and the possibility of secreting medication to use later to overdose • the LSCB should seek to learn from the wider picture and research into adolescent self-harm and suicide to consider prevention and treatment options in the commissioning and provision of local services • teachers may not have had training in young people's mental health especially acute mental ill-health and its management • the need to increase understanding of the impact of social media on young people's decision-making and actions. **Recommendations:**

		• expedite publication of a Local Strategy for Prevention of Suicide by Young People and whether this should be a Strategy to prevent harm and suicide by young people; to raise awareness and learning between schools about children's mental health and risk • to seek reassurance from partners that there is a robust and coordinated response to suicide by a young person, to identify and mitigate the impact on other children and young people.
2019- City and Hackney LSCB –X Death by suicide of a 16 year old boy	Death of a 16-year-old-boy by suicide in October 2016. X was known to local health services and had been receiving intermittent psychological support for his anxiety from the age of 8. X had generally good school attendance and was expected to do well in his exams. His parents were seen as supportive by the school. X told his parents that he had taken an overdose and was taken to hospital; he was treated and released to return home with his parents with a safety plan the next day. His parents checked on him regularly through the night, when they went to wake him at 11 he was found to be lifeless. An ambulance was called that verified he was dead. Ethnicity or nationality is not stated. <u>Overview report</u>	**Learning** • more preventive approaches are needed to support young people who are anxious and help prevent them acting on suicidal thoughts • more support should be available for young people to talk to others if they are feeling anxious or depressed. **Recommendations** • raise awareness about the use of and impact of illegal drug use by young people; consider the role of drug and alcohol use in mental health assessments of suicidal young people • schools should ensure that a child's vulnerabilities including mental health issues should be passed onto a new school when a child transfers • hospitals should ensure that there is enough provision for adolescent and child mental health services at night and weekends.

2019- Croydon- LSCB Vulnerable Adolescents Thematic Review	Thematic review of 60 vulnerable children (23 girls, 37 boys) aged between 10 and 17-years-old. Review instigated after five children died between July-December 2017 from stabbing (three), ingestion of drugs and a road accident. All 60 children were known to Croydon Children's Services; 44 were known to Youth Offending Services. Highlights themes experienced by cohort including: poverty; housing; parental issues; domestic abuse; children's services; looked after children. Black boys of Caribbean heritage and white girls of British heritage are the two largest groups in the cohort. Overview report	**Learning:** • a holistic approach to the child and family is needed, complemented by an integrated multi-agency response • making a difference to children's outcomes cannot be achieved by professional intervention alone and there is a need to understand and embrace family, kinship and communities • schools should be equipped to respond to challenges presented by children with high risk behaviour and placed at the heart of multi-agency service provision. **Recommendations:** • Consider how awareness raising about the impact of adverse childhood experienced (ACEs) will be built upon to include professionals, families and the community • establish a data set about the most vulnerable children in Croydon to inform risk management strategies and service provision • consider how the involvement of professionals, families and the local community might be achieved, to explore how to address disproportionality.

HOMICIDE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2019- Tower Hamlets LSCB – Child Elias Death of a 14 week old boy from serious non-accidental head injuries	Death of a 14-week-old boy from serious non-accidental injuries in July 2016. Elias lived with his mother, sibling and three half siblings at the time of his death. Mother married Father 2 under Islamic law but he had another family. The eldest child had a diagnosis of Autism and Elias was born with a hand deformity. Family known to Children's Social Care and Police for domestic abuse with Father 1 and allegations that mother was mistreating the children. Elias taken to hospital by ambulance after mother found him unconscious. Mother and Father 2 were arrested for grievous bodily harm and siblings taken into local authority care. Mother of Bangladeshi origin. Methodology: a systems based approach to meet learning and improvement requirements of statutory guidance. Overview report	**Learning:** • failure of the systems and processes designed to safeguard children with inaccurate recording • the interface between Child in Need and Team Around the Child did not work well; system around midwifery care was disjointed with lack of communication between midwifery teams and midwives and GPs • insufficient focus of emotional impact of Elias and Child A's diagnoses on their parents. **Recommendations:** • health services should review documentation and assessment tools and include household composition and functioning of the household • to seek assurance from health and partner agencies of emotional impact of having a child born with any abnormality/disability features within consultations with recognition of any risks to the child • all GPs to be notified of the pregnancy of all women registered in their care • to seek assurance that the application of thresholds is now consistent.
2018 Bristol Safeguarding Adults Board – Kamil Ahmad and Mr X	In 2016, Kamil Ahmad, a Kurdish male who arrived in the UK as an asylum seeker, was murdered by Mr X, a white British male. Both men	**Learning:** • It is vital that tribunal processes are provided with full and complete

Murder of Kamil Ahmad a Kurdish male asylum seeker by a white British male when both were living in supported accommodation. The SAR found that Kamil's murder could have been prevented.	were residents in the same supported accommodation provided for individuals with mental health needs. Kamil had been living in the shared accommodation since 2013. He arrived in the UK as an asylum seeker and had a diagnosis of PTSD and OCD. He may have also had a learning disability, this was being assessed at the time of his death. In the years they had lived in the same provision, Mr X had racially abused and physically assaulted Kamil on a number of occasions. Mr X had a significant forensic history and had been detained in secure mental health facilities for a large part of his adult life. Mr X displayed resentment towards Kamil due to his race and status as an asylum seeker. The fatal assault occurred soon after Mr X had been discharged from hospital where he had been detained under Section 2 of the Mental Health Act. The SAR found that Kamil's murder could have been avoided. SAR Briefing	information including of historical behaviours and risk, by all relevant organisations most particularly mental health trusts • Discharge planning (s117 aftercare) should include relevant providers, landlord services and police when a crime has been committed before an inpatient stay Care Programme Approach multi-agency meetings should be held for adults with mental health needs when risks escalate or new significant risks are identified • Services must be aware of the impact of unconscious bias. Use of language such as 'failed' rather than 'refused' asylum seeker may unconsciously change how services regard need and support • Interpersonal risk assessments should be undertaken by accommodation providers to consider risk between individuals • Eviction processes take time to evidence and proceed through court. Multi-agency services should have discussions with landlord services about the need to terminate tenancy at the earliest opportunity. Multi-agency safety plans should consider impact of medication changes on behaviour particularly considering previous reactions to medication change • Alcohol use should be robustly assessed and reviewed as part of care plan even if

		the individual is refusing to engage with specialist services • Safeguarding enquiries and care act assessments should include relevant voluntary and community sector services including, where relevant, services for refugee and asylum seekers • Hate crime assessments should recognise the increased risk when victims of hate crime live within same provision as a perpetrator • Perpetrator/s of hate crime using language such as 'paedophile' or 'terrorist' should be warning signs of increased risk to victims • Victim care services should offer a flexible tailored approach to enhanced victims, particularly recognising the needs of those for whom English is not their first language or where there may be additional barriers such as in the case of refugees and asylum seekers

ADULT NEGLECT		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
October 2018- South Gloucestershire Safeguarding Adults Board – Nightingale Homes – Neglect	Nightingale Homes Ltd ran three residential homes in South Gloucestershire, to provide care and support for people with learning difficulties and mental health needs. They were known as Bedrock, Lodge, Bedrock Mews and Bedrock Court. In 2016 CQC inspections rated them all as inadequate and despite the efforts of a	**Learning:** • Some agencies did notice concerns but were not able to rate what they saw as a meaningful concern and practitioners defaulted to the perceived 'expertise' of the staff

	'turnaround' team they closed in 2017. In Sept 2017 SGSAB commissioned a review, in particular to identify how failings in the homes were not recognised when there was so much professional interaction with residents. The issues included • inconsistent management and leadership • lack of insight as to how to improve the service • lack of staff training • no understanding of the Mental Capacity Act 2005 • unsafe medication practice • care not person centred • risk management plans inadequate • inadequate staffing levels at night and during the day • dignity was not observed • staff were observed to be rude and disrespectful • registered manager was resistant to advice • Care planning, the rigid routines within the service and staff approach to people, all contributed towards dependence being fostered. People had lost, or did not gain, independence. • the experience of people using the service was of a closed environment. They lived at the service, used the day care facilities at the service and activities and holidays took place mainly in groups. People were not encouraged to have contact with family or friends.	• 10 residents were not visited by the placing authority in the period of the review, not all placing authorities are fulfilling their statutory duty to review adults care and support needs • Families were rarely invited to reviews There was little professional curiosity or challenge • There was a view that 'someone else was concerned & doing something' • When a practitioner had a concern this was escalated within their own local authority and not to South Gloucestershire • Placing authorities did not follow the ADASS Out of Area Safeguarding Arrangements (2016) • Placing authorities are not fulfilling their obligations to inform a host authority of people placed in their area. South Gloucestershire currently has no mechanism to capture or use this information **Recommendations** • The residents and families had no way of rating or judging their experiences. The SGSAB need to think about ways to communicate with people to know what they should expect, and what is, and isn't good practice • SGSAB is recommended to commission the production of a Guide for professionals, adults and their families or representatives on standards, i.e. "what

	SAR report	to expect" from a good care home. The guide must be accessible and contain clear information on what to do if expectations are not being met. The Guide must be person focused, using the standpoint of the person living in the service, i.e. would I want to live here? • SGSAB is recommended to assure itself that all Partner agencies are aware of how and when to contact local adult safeguarding services, including the current Deprivation of Liberty Service. This will involve: (1) Clarifying what is adult safeguarding, and what is poor practice or a "quality" concern (2) Specifying the routes for concerns and the expectations of reporting on all agencies, including those who place in the local area. (3) All agencies having full involvement in expressing concerns and contributing information regarding concerns. Agencies must be told what the response to their concern is, and if there is no response they must be aware of how to escalate concerns that they believe need an adult safeguarding or quality response. • South Gloucestershire Commissioners are recommended to produce a set of standards for commissioners placing in the South Gloucestershire Area. • South Gloucestershire commissioners must set out their plans for assessing the quality of provision in the local area.

		• South Gloucestershire Council must develop a mechanism with which to capture information about the people placed in its area. • Adult Safeguarding Services are recommended to develop a tool with which to systematically evaluate indicators of potential organisational abuse.

ADULT - SELF NEGLECT AND HOARDING		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2018- Suffolk Safeguarding Adults Board – Mr B Self Neglect and Hoarding	Mr B, aged 61, who had mild learning disability, died in June 2017 from smoke inhalation during a house fire in the early hours of the morning. His friend Mr C, who lived with him, also died in the fire. The conditions in their home showed a pattern of extreme hoarding and severe neglect of cleanliness and hygiene. Mr B's personal care was also severely neglected. They were well known to a number of services, who at the time of their death were pursuing a risk management plan under the safeguarding procedures of the Suffolk Safeguarding Adults Board. A Fire Investigation Report by Suffolk Fire & Rescue Service concluded that the fire resulted from electrical failure of a toaster. A Sudden Death Report by Suffolk Constabulary concluded there was no evidence of any third-party involvement in the fire, and that it had been a	**Learning:** • Early missed opportunities to conduct care & support needs assessment. • Reliance on assumption of capacity rather than formal process of assessment. • Mental health needs recognised too late in the process • AM's assurances taken at face value - absence of professional curiosity. • Loss of momentum in response to continued refusal to deal with the state of the property. • Coercion and control of Mr. B recognized but not addressed. • Some evidence of a lack of multi-agency communication and collaboration

	tragic accident but queried whether preventive action could have been taken. SAR Executive Summary	• More proactive communications with Mr B's family could have resulted in a stronger presence for them in his life. **Recommendations:** • The appropriate application of the Mental Capacity Act, especially regarding the presumption of capacity, best interests and executive capacity is vital is such cases • The needs for mental health assessments needs to be recognised early in the engagement process • Partners need to recognise the impact of coercive and controlling relationships on the risk assessment process • Consideration should be given to the need for a mental capacity assessment for carers where doubt exist about their ability to make specific decisions • Comprehensive multiagency strategies are needed during the relationship building work, notably to ensure that key agencies such as the Fire Service and Police were able to input to discussion and decision-making • There needs to be collective ownership of self-neglect cases, core membership of multi- agency meetings, and nomination of a case coordinator