Luton Safeguarding Adult Board

Report of Safeguarding Adult Review

'Leah'

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1. Introduction

1.1. This Safeguarding Adult Review (SAR) was commissioned by the Luton Safeguarding Adult Board in March 2023 following a rapid review to consider the circumstances and learning for agencies resulting from the death of Leah who took her own life. The circumstances of Leah's death were included a background of self-harm, drug use, homelessness, mental health problems and suicide ideation. Leah reported having been subject to financial, physical and sexual abuse in the months before her death. She also shared that she had a history of child on parent violence relating to her son but she subsequently retracted this disclosure. Leah was known to anti-social behaviour services and received an injunction due to her starting small fires in residential housing.

1.2. Under the 2014 Care Act, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs). The Care Act 2014, sections 44(1), (2) and (3), requires that a Safeguarding Adults Review (SAR) is undertaken where an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse, including self-neglect, and there is concern that agencies could have worked better to protect the adult from harm. Under section 44(4) a SAR can be undertaken in other cases concerning adults with care and support needs.

1.3. The *Care and Support Statutory Guidance (*DHSC, 2020*)* is also clear that the types of abuse or neglect given in the Guidance is not exhaustive and sets out that '*local authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered'* para 4.17. This supports the view that concerns regarding suicide and self-harm should be taken on a case-by-case basis and considered against section 42(1) where an adult:

a) has needs for care and support (whether or not the authority is meeting any of those needs),
b) is experiencing, or is at risk of, abuse or neglect, and
c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

1.4. While not all cases of suicide will meet the criteria for a Safeguarding Adults Review there is evidence of multiple forms of abuse suffered by Leah and a significant history of self-neglect which is likely to have contributed to her decision to end her own life.

1.5. As outlined in the Local Government Association guidance as to what constitutes a safeguarding concern[1], '*Suicide, or threats of suicide may often be tied into many other complex issues, which can be connected back to self-neglect...The s.44 criteria for SARs specifically highlights this subject*.' Given the concerns, in this case, regarding abuse and neglect and, about how agencies worked together, the LSAB determined that a SAR was necessary in Leah's case.

[1] https://www.local.gov.uk/understanding-what-constitutes-safeguarding-concern-faqs

2. Background to the Review

2.1. Leah was found deceased in her accommodation in November 2022. She had taken her own life by hanging. Leah was aged 41 years when she died. She had a long history of mental health issues and variable engagement with local adult mental health services. Leah was also being supported under a multiagency complex panel for vulnerable adults. Leah demonstrated a range of challenging and escalating anti-social behaviours and as a result she was due to be evicted from her accommodation on the day she died. This immediate stressor and the multiple types of abuse she had experienced were thought to be a factor in her decision to take her own life.

2.2. The LSAB held a rapid review meeting on 6 March 2023 to review the multi-agency response to Leah which determined that the criteria for a SAR were met. The LSAB Case Review Group agreed that, while the case met the criteria for a SAR, there was a need to think laterally about the review process to ensure linkage and learning from the case to previous reviews as there is significant similar learning. The next steps were agreed for the LSAB Strategic Business Manager to consider the terms of reference against similar reviews to identify gaps and what more we might learn in a reflective and proportionate learning approach.

2.3. A proposal was made to Case Review Group in May 2023 that, in the light of the learning gained from the previous reviews such as the Thematic SAR Mental Health, Abdullah and the ongoing Integrated DHR/SAR 'ANNA' whose subjects had similar circumstances in their history, that the LSAB should use this as an opportunity to test the impact of the activity already undertaken as a result of these reviews against what happened in the Leah case. This would include utilising the material from the rapid review for Leah to consider what worked well, any challenges or barriers to practice and any further emerging learning. As a result, it was agreed to undertake a Learning from SARs Development Day and a desktop review utilising the extensive Rapid Review materials. This meeting took place in November 2023.

2.4. However, once the review had commenced and the early analysis report was reviewed by the Luton Joint Case Review Group, it was agreed that the criteria for a Domestic Homicide may also have been met. This was because of reference to Leah having experienced child to parent abuse from her adult son during the period under review. Leah's case was therefore, also presented at the Domestic Abuse Luton Programme Board in July 2024 who agreed that the criteria under *section 9(3) of the Domestic Violence, Crime and Victims Act 2004* and within section 18. of the statutory guidance for Domestic Homicide Reviews were not met[2]. It was agreed that any relevant learning from the SAR would be shared with them for their consideration.

[2] https://assets.publishing.service.gov.uk/media/5a80be88e5274a2e87dbb923/DHR-Statutory-Guidance-161206.pdf accessed in April 2024.

3. Review's Scope and Focus

3.1 The review was therefore set up to complement the focus within the above referenced previous SARs and other reviews in the following areas:

- Is there clear guidance within the safeguarding system about the thresholds for and methods of intervention in relation to those with complex needs. Particularly those with dual diagnosis mental health and self-neglect linked to self-harm and suicide.
- What criteria within the Section 42 enquiry were considered? How did the local authority satisfy itself that a safeguarding enquiry was not needed to help it to decide what action to take to support and protect the persons in question?
- Did practitioners demonstrate a good understanding of the lived experience and circumstances of Leah including her ethnicity and culture and if not, what were the barriers to this?
- Was the intervention provided timely or were there delays in responding, and if so, why?
- Did practitioners fully consider whether Leah had "capacity" to manage her daily life and make decisions - based on having decision-making capacity - to keep herself safe?
- Do practitioners know who they can turn to for expert advice and support in these areas if an adult is at risk but uncooperative and inconsistent in their engagement with services?
- How well does the commissioning function across the partnership facilitate identification or creation of accommodation-based support that can meet complex needs and how responsive is this to periods of crisis?
- How does local availability of resources impact on care planning and safeguarding?

3.2 The period set for the review of practice in relation to Leah's case was December 2020 to December 2022. There was also consideration of earlier service involvement where it is relevant to system learning for the multi-agency safeguarding system.

4. Review Methodology

4.1 A Systems Practice Model has been used as the methodology for this thematic SAR. It has focused on the actions and decisions of the individuals and agencies who were directly involved, to understand and distinguish the influence of a range of organisational factors in the decisions and actions taken.

4.2 The SAR has built upon the learning from the key events within chronologies and rapid review reports from those agencies which were involved, practice discussions within the rapid review itself to explore good practice, missed opportunities and emerging learning.

4.6 The review has therefore included:

- A review of the records relating to Leah including the rapid review report and chronologies from each of the agencies who were involved with her.

- Family engagement was planned to take place and it is planned to share the report with the family who were involved in the Coroner's inquest which concluded in July 2023 and the outcome report received in February 2024.
- A brief report by the independent reviewer, focusing on learning rather than the events including:
    - Whether there is evidence of practice improvement from earlier reviews.
    - A conclusion as to whether as a result of learning from this case, any changes are required to practice, policy or procedures by individual or collective agencies.
    - Recommendations demonstrating responses to the Case and System Issues identified.

5. Agency Involvement

The following agencies were involved with these Leah:

- Bedfordshire Hospital NHS Trust
- Bedfordshire, Luton and Milton Keynes Integrated Care Board
- Bedfordshire Office Police Crime Commissioner (OPCC) Victim Services and Commissioning
- Bedfordshire Police
- Cambridgeshire Community Services
- Creative Housing Management
- East London Foundation Trust (Adult Mental Health Services)
- East of England Ambulance Service
- Luton Borough Council: Adult Social Care, Early Intervention Prevention, Adult Safeguarding
- Luton Borough Council: Housing Dept including Rough Sleeping Team, Neighbourhood Services, Housing Solutions
- Signposts Luton
- Victim Services – commissioned by Office of Police and Crime Commissioner

6. Family Involvement in the Review

6.1 As part of the review process, the reviewer has tried to make contact with the family of Leah. A letter explaining the process was sent to her family members but no response has been received to date.

6.2 A further attempt was made to contact the family once the review was completed to share its findings with them and to give them the opportunity to comment on the services received by Leah.

7. Profile of Leah and Details of the Agency Involvement

7.1. Leah was a 41-year-old female who had been born in Algeria and came to the UK as a child. She was of Brazilian, Arabic and African ethnicity. She had a son with whom she had lived during the period under review but they had a difficult relationship at times including reported child to parent violence and abuse during his teenage years. Leah is also reported to have suffered serious domestic violence in her intimate relationships.

7.2. Leah had a long history of police involvement and had been known to Bedfordshire Police since 1997, initially as a victim, but later as both a victim and as a perpetrator of offences. There were 65 separate records within the police Athena record system from 2019 onwards and there was further information in the legacy recording system used prior to Athena.

7.3. From 2019 onwards, Victim Services were involved with Leah on twelve occasions for a range of offences such as harassment, domestic abuse, public order offences, alleged theft as well as alleged sexual offences. Leah, especially in the year proceeding her death, lived a highly chaotic lifestyle and was very vulnerable to exploitation and abuse.

7.4. Leah had originally been housed with her 21-year-old son but Neighbourhood Services received a series of reports of antisocial behaviour. These included vomiting over the balcony, waste coming from the flat and arson. In October 2021, Leah, lit an envelope which set off a smoke detector and fire alarm to the building. A safeguarding referral was made, and a multidisciplinary safeguarding meeting was held in early November, with an outcome of section 42 enquiries to be made. There were more complaints in relation to Leah setting fires within the property where she set door spyholes alight, so that residents were unable to use them for their own safety.

7.5. In February 2022 it was reported Leah had set fire to another resident's property by lighting and placing paper through their door. The same day there had been a report of a domestic abuse incident by Leah asking for her son to be removed temporarily from her property as he was causing her distress. Her son had reportedly verbally abused her by calling her derogatory names relating to her appearance. There was no evidence of assaults or threats made and no offences apparent.

7.6. The reported arson incident resulted in the Police arresting Leah and making a referral to the ELFT Community Mental Health Team (CMHT), her GP and to LBC ASC. Although the concerns progressed to a section 42 enquiry this was linked to an open section 42 enquiry already with ELFT as her care coordinator. It was sent to the ELFT Liaison Patient Team with advice given to link with ELFT CMHT which was believed to be the allocated social care team for Leah's ongoing needs. The referral advised the Mental Health Liaison and Diversion nurse had assessed Adult in custody while under arrest for arson.

7.7. While in custody, Leah alleged a neighbour had raped her and she believed her drink was drugged because she woke up in a state of undress and she had been drinking with them the previous night. The allegations were investigated and a file built but were filed as no further action due to insufficient evidence following Leah's death.

7.8. The ELFT mental health assessment undertaken while Leah was in custody reported that she had taken three overdoses in the past with an intention to end her life and that she was a victim of domestic abuse from her son. Her mental health was said to be deteriorating due to social stressors. However, Leah denied abuse from her son and said he was helping her with most things. During

this assessment Leah disclosed that she had been raped by someone known to her. Following this assessment, a further safeguarding concern was raised by ELFT for possible ‘sexual abuse’ relating to the above disclosure. This was passported back to ELFT to link to the open and ongoing section 42 enquiry.

7.9. Leah was referred to the ELFT Crisis Home Resolution and Home Treatment (CRHT) team for immediate support and a referral was made to the CMHT for longer term support. However, Leah did not engage with CRHT, so was discharged back to her GP. CMHT also declined to accept the referral received from the Luton and Dunstable Hospital due to Leah being open to the CRHT. This resulted in Leah not receiving a service from either team. Although the section 42 enquiry remained open on the Adult Social Care records.

7.10. As a result of the arson incident and a history of other antisocial behaviour incidents LBC Neighbourhood Services sought a ‘*without notice injunction*[3]’ to prevent Leah from coming back to the property, thus evicting her and making Leah homeless. Leah was placed in Luton temporary accommodation. There were no issues noted by LBC and the Housing Officer’s only involvement was to deliver the ‘*discharge of duty’* letter and to change the locks.

7.11. In March 2022, Leah breached her court order not to visit her son’s flat following her eviction and injunction. Bedfordshire Police received a report of domestic assault, kidnap and threats, this was said to be because of Leah entering her son’s flat to retrieve her possessions. Leah was placed in the Luton Residence Hotel for four weeks after which a discharge of duty letter was delivered by LBC Housing Management and the locks changed. In April 2022 Leah was placed in custody for breaching the injunction and at court she was given a custodial sentence suspended for two years. Leah was moved to accommodation provided by Signpost Housing. Police officers visited her about her allegations of domestic abuse against her son.

7.12. The police officers noted that, because of the above interactions, the relationship between Leah and her son was volatile and toxic and she had said in previous encounters she feels that he is dangerous. However, when seen Leah stated she had not been assaulted. She said she had locked herself out on the flat balcony as she was paranoid and she escalated the situation further by doing so. Leah stated that while her son did grab her coat collar, this was due to her locking the front door and she made the allegations as she was emotional due to not taking her medication. Leah signed the officer’s pocketbook entry to this effect. No referrals were made regarding this episode and no further action occurred.

7.13. In May 2022, Leah attended the Signpost accommodation office at around 21:30 in a distressed state and alleged that another resident had started harassing her in a sexual manner after she moved in. The resident had initially been kind and helpful to her so they had exchanged mobile numbers. Leah showed staff numerous unread text messages and photographs in her chat history. Leah stated that the resident had touched her inappropriately several times and sent explicit photographs of himself. Leah then stated he had tried to enter her room on multiple occasions and exposed himself to her in the shared kitchen.

[3] https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part25/pd_part25a

7.14. The night staff advised Leah to speak to the day staff as this was an ongoing issue. They stated that they would make day staff aware of her concerns. Leah stated she was afraid the harassment would occur during the night, so staff assured her they would speak to the resident to ensure this would not happen. Leah then returned to her room. Leah made allegations to the police that a resident had threatened over not lending them money. The resident made a counter allegation that Leah entered her room while she was asleep and tided the room but also stolen items. No further action was taken or referrals made.

7.15. Leah was then spoken to two days later by Signposts staff to find out if she felt safe or if she wanted the resident removed. Leah responded that as he had been spoken to by night staff it should be all right. Leah showed the worker some indecent messages from the resident. The worker noted that while Leah had answered some messages but they did not relate to the previous messages. Leah confirmed she had not heard from the resident since he was spoken to by staff. However, staff at Signposts did not report the matter to police or make any safeguarding referral to ASC about the concerns they had been made aware of which related to possible sexual abuse and or exploitation.

7.16. In early June 2022, Leah came to the Signposts office and asked to speak to staff. Leah advised them she no longer felt safe in the building as other clients were talking about her and accusing her of being an undercover police officer. She was advised that if she did not feel safe further possible actions could be discussed with management although not specified in their records.

7.17. In mid-June 2022 Leah made allegations to the Signposts staff in the office about another female resident being called racist names by another male resident. Leah was unhappy with the proposed solution which was for her to speak to the on-call staff and to report the incident to 101. Although the other female did not want staff to report the incident, Leah made allegations related to drugs and sex trafficking and came back into the office demanding it was reported. Signposts staff could have shared this information through the Police multi-agency intelligence form which would not have needed the other resident's permission and which may have helped Leah feel heard.

7.18. The following day Leah was moved to another Signposts' accommodation. She was seen by their staff the following day, but then there was no contact with her for one month. Leah advised then that when she arrived at the new accommodation the male resident who had been accused of sexually harassing her was in the office. Leah said she froze due to the history between them and had not been at her accommodation due to this. Leah said that she wanted to move out of Signposts away from alleged drug and alcohol users.

7.19. In early August 2022, Leah came to the Signposts office upset and she showed a text dating from May 2022 from the male resident she had previously raised concerns about. She explained her continuing concerns although she said there had been no new issues and her distress was because she felt anxious and nervous in case she saw him. Two days later Leah made allegations that another resident was "cooking drugs and selling them". She said that she did not feel safe, as some of the clients were using needles in front for her. Two days after

this, she made allegations of inappropriate behaviour against a staff member at her previous Signposts accommodation.

7.20. The following day it was decided by Signposts that the best option would be for Leah to be offered a room in alternative accommodation which was staffed 24 hours per day so she would feel safe. Leah was advised the offer included support in external accommodation as well as support to get onto the bidding list. As Leah seemed reluctant the worker agreed to return to discuss the options further later that day.

7.21. A member of staff called the Police to say that Leah was refusing to return the key to her room and shouting *"rapist and drug dealers*" outside the building. Police Officers arrived and took Leah to their car to speak to her. Other police officers entered the building and advised that they were there to arrest a male resident for the alleged attempted rape in May 2022 at Leah's previous address. The Police requested information from the Signposts' records regarding their staff's knowledge of any incident. Leah was escorted to her newly allocated accommodation by police officers and her admission paperwork was completed by staff there. Officers bailed the male resident to a different address to Leah.

7.22. In mid-August 2022, Leah was found by staff sleeping in a male resident's room. Leah was advised that whilst there were on-going investigations it would be in her best interests not to put herself in vulnerable situations such as sleeping with another resident. She stated that she agreed with this and that they had been watching a film and both fell asleep.

7.23. The next day Leah was seen by staff on shift and Leah was told not to sleep in that resident's room again. Leah said the resident was not well and she was worried but she did not go and tell night staff. Over the next few days Leah complained that another resident was taking drugs from her boyfriend and then selling them in the accommodation. Leah then said she was afraid of the resident in whose room she had slept because he had allegedly threatened her and had scratched and burnt her.

7.24. A member of the Housing staff supported Leah to make a homeless application to LBC as it was believed that shared accommodation was unsuitable for her to continue to occupy. Leah reported that '*she felt lighter and hopeful that she has a future*'. The planned move was to take place in a few days but Leah said that she was not yet ready to go. However, she agreed to get ready and said that she was very happy about moving from the House of Multiple Occupation (HMO). Leah made the move and was left with her belongings at the hotel.

7.25. At the end of August 2022, ASC received a MASH Referral from Signposts regarding the above incidents and concern regarding her spending the night in another resident's room due to her vulnerabilities. She reported that another client in the project was making her "do drugs" and hitting and stealing from her. Leah also alleged she had been subject to an attempted rape in the previous accommodation. Leah claimed a male staff member had sexually assaulted her in her previous accommodation and this was 'taken care of by management.' Both incidents were reported as historical. The police were recorded to have attended and taken action.

7.26. The MASH outcome was a recommendation for ongoing case management by ELFT, and, looking at the number of allegations raised within a short space of time, recommended a mental health assessment to be completed. Contact was established with ELFT CMHT who agreed to assess and to request review by a psychiatrist and advise ASC of the outcome. In late August 2022 a homeless application was made with Leah by Signpost staff and a request made she be placed in temporary accommodation.

7.27. After Leah had reported being a victim of a crime the police contacted her in the second week of September 2022. The police were concerned for her Mental Health as she was said to be in 'a dark place' and that she 'couldn't go on anymore' following a disclosure to the sexual offences team. The ambulance and Mental Health Street Triage attended and assessed her. Leah was not taking her medication due to having lost her prescription. Leah was recorded as having fleeting thoughts of suicide which were chronic in nature, and emotional dysregulation to social stressors. She had therefore been referred back to the ELFT CMHT. It is not clear from the records whether contact as made with her GP for a new prescription for Leah.

7.28. The Homeless Team were also contacted and arrangements were made for Leah to stay at the hotel for one more night as she was due to be evicted and for her to be assisted in the morning. No safeguarding referrals were made to ASC as her case was already open to ELFT for assessment. The following day housing called Leah to seek an update on her current circumstances. Leah informed housing that the police and crisis team attended the hotel and she stated the hotel 'just wanted her out' because of her mental health and as she was at high risk of suicide.

7.29. Leah advised she was not feeling suicidal just feeling very poorly and if she were evicted she would have nowhere else to go and would be homeless. LBC housing staff agreed to investigate alternative accommodation. Three days later when they tried to get hold of Leah on her phone number, they updated her friend who answered her phone and asked them to update Leah that a housing officer would be in touch and come to see her and she would be moved to Luton Hotel Residence (LHR) that day. The friend advised she would stay and support Leah until she was moved from the hotel.

7.30. The Homeless Team met Leah at LHR and she sought to embrace staff as she was so happy to have somewhere else to live. The housing staff met with Leah in her room and discussed how she was coping now. Adult MD stated that she was doing well and that her newly prescribed medication was working well. They discussed with Leah her personal housing plan (PHP) which she stated she was happy with. The PHP[4] identified steps which the local authority would take to prevent or resolve Leah's homelessness and her responsibilities. Leah was

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4 https://england.shelter.org.uk/professional_resources/legal/homelessness_applications/personalised_housing_plans/local_authority_steps_in_personalised_housing_plans#:~:text=The%20personalised%20housing%20plan%20(PHP,or%20relieve%20the%20applicant's%20homelessness. Accessed 08 February 2024

reminded that if she lost her placement at the LHR there would be nowhere else LBC housing could place her.

7.31. The following week there was an email exchange between Leah, LHR, LBC housing and allocations staff who had offered Leah accommodation within an all-female HMO. Leah advised that she would not be able to maintain staying at an HMO as she felt vulnerable and that they had always failed. Following an inter-agency conversation housing allocations agreed to refer Leah to CC Housing for a self-contained one bed flat. Leah provided medical evidence from the medical staff responsible for her care. Leah also discovered that all her belongings at her previous accommodation had been thrown away as she had not collected them within 14 days. Leah was very distressed at this news and she asked for the Signposts CCTV footage to see if she could retrieve her belongings.

7.32. ELFT CMHS responded to LBC housing needs to advise that at present Leah is not on Care for people with mental health problems (Care Programme Approach)[5] (CPA) and is therefore open to the CMHT under the care of a consultant psychiatrist. However, they also advised that her allocated consultant has recently left the team and we are awaiting a new consultant. Therefore, they were trying to arrange an outpatient appointment with the available psychiatrist for further assessment.

7.33. LBC Housing needs spoke with Creative Change Housing Management (CCHM)[6] Supported Housing Manager, Luton to share health information regarding Leah and that she has a heart condition and mental health issues and that she is currently engaging with CMHT and said to be responding well to her current medication. Her history of making sexual allegations against male members of staff when lone working was discussed and that requiring work in pairs while working with Leah. CCHM agreed to assess her suitability for accommodation.

7.34. Within 48 hours, Leah was offered a one bedroom self-contained flat by CCHM. Having viewed the accommodation Leah accepted the flat, signed the tenancy, collected the keys and made plans to move in over the last weekend of September. However, before Leah moved into the flat she was taken to hospital by the East of England Ambulance Service for heart problems. Leah contacted LBC housing and CCHM to advise she was in hospital after suffering a heart attack. Leah was advised her tenancy at LHR had ended and she said CCHM had confirmed her flat was being kept open for her.

7.35. While an inpatient the Luton & Dunstable Hospital referred Leah to LBC Adult Social Care as she stated she had been attacked by her son. However, she denied this when spoken to and instead wanted to speak about another resident in the building who she alleged had been acting "*funny*". The ASC MASH Outcome for this referral was for information and advice and ongoing case management by CMHT as this was a historical known concern previously considered by Bedfordshire Police.

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[5] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/ accessed September 2024.
[6] https://cchousing.co.uk/ accessed September 2024.

7.36. In mid-October 2022, Leah made a report to police that a male known to her had used crack cocaine and passed out on her bed in her new flat. Leah stated she tried waking him up and told him to leave and he became angry, began to touch her sexually and made threats to rape her. Leah reported to police that she managed to escape and alert the security guard who then called the police. However, there was insufficient evidence to bring any charges.

7.37. The following week there was a report of a verbal argument between Leah and her adult son, however, they both declined to speak to the police. No details of the argument were provided to the police and no safeguarding referrals were made. The following day Leah was conveyed to hospital by ambulance for an ongoing medical condition.

7.38. By early November 2022, the Police received several complaints of harassment from Leah. She reported that a male who lives in the same flat block has been repeatedly calling, messaging, and knocking at her door. Leah stated she feels like she has to go and see him because he tells her to and because she needs support but does not want him to keep coming to her flat. Leah blocked his number, and police advised him not to make any further contact.

7.39. The following day Leah reported that a neighbour has stood outside the address shouting her middle name for her to come outside and she has hidden in the wardrobe. She has then gone outside for a cigarette and he has started shouting at her demanding he comes in her flat and she ran away. Between stated times and stated dates police attended the location following reports that money had been taken from her account. On police arrival it transpired that Leah had 'willingly' changed her benefits to go into the suspect's account. The suspect had been given a verbal warning less than 24 hours previous not to contact Leah anymore. However, no referrals were made despite Leah's vulnerability and the risk of her having been coerced and of being financially abused.

7.40. Over the next few days, the police attended Adut Leah at home due to her reporting that one of her neighbours is harassing her. They concluded that Leah 'clearly has a vendetta against the neighbour' and had made up numerous false allegations against the neighbour which have been proven to be incorrect via CCTV. There were concerns for Leah's mental health as she appeared paranoid and whether this was due to drug use. As a there were also concerns for her physical health a referral was shared with adult safeguarding and ELFT.

7.41. The day before her death Leah contacted the ELFT Mental Health Community Liaison (MHCL) worker and reported her distress about an incident where she was alleged to have stolen a laptop from the accommodation provider and as a result was going to be evicted. MHCL staff contacted and discuss Leah's case with CCHM accommodation staff who confirmed Leah had returned the laptop when confronted and made comments of feeling suicidal. Both police and EEAS ambulance service had been called to assess Leah's mental health.

7.42. Police officers went to speak to Leah and to check on her welfare and she told them that she had been feeling like 'she wanted to end it' and was fed up, 'she did not want to be in pain anymore'. Leah stated she felt very alone and like she could not leave her flat to get food as she did not feel safe in the area. The

ambulance called by CCHM staff due to Leah stating she was suicidal and locking herself in her flat was cancelled by the police in attendance, as she had now unlocked her door and was talking to them.

7.43. An officer offered to take Leah to the hospital voluntarily but she refused on several occasions. Advice was sought from the Street Triage team but as she had full capacity and was in her home the police had no powers to remove her. They advised her they would complete a safeguarding referral for her. Leah stated she felt better knowing that and she was not going to harm herself. Leah was advised to call her GP, adult safeguarding and her mental health crisis team in the morning. MASH and ELFT received a referral the following day.

7.44. Shortly after the officers left Leah sent the CCHM worker a message stating, *"I promise you that this will be on you and your accusations*". This information was shared over WhatsApp and at handover with the night staff but they were not specifically told of her threats to end her life. The night worker knocked on Leah's door later that night and returned with the keys to the door as they had received no response from Leah. They tried to unlock the door, but it was double locked from the inside so they were unable to gain entry.

7.45. The following day in the afternoon two CCHM staff members attempt to open the door to Leah's flat but could not gain entry. An hour later staff put the eviction notice under the door of her flat and shouted through the door. CCHM staff then gained entry with the help of a maintenance person and discovered that Leah appeared deceased and to have taken her own life by hanging. An ambulance attended shortly thereafter and Leah was declared deceased.

8. ANALYSIS OF AGENCY INVOLVEMENT

- **Is there clear guidance within the safeguarding system about the thresholds for and methods of intervention in relation to those with complex needs. Particularly those with dual diagnosis mental health and self-neglect linked to self-harm and suicide.**

8.1. Thresholds were applied based on Leah's engagement with services and the severity of her mental health and behavioural issues. Leah was discharged from the CMHT due to non-engagement but was taken back on due to concerns about arson rather than due to thresholds for and methods of intervention in relation to those with complex needs. Despite multiple referrals and assessments, her lack of consistent engagement affected the application of thresholds for more intensive support.

8.2. The housing provider did not have the specialist mental health support needed, and there were issues with risk assessment and escalation procedures. There appeared not to be clear guidance within the safeguarding system to support adults with complex needs and the disjointed nature of communication between agencies affected the application of practice guidance for more coordinated support.

- **What criteria within the Section 42 enquiry were considered? How did the local authority satisfy itself that a safeguarding enquiry was not needed to help it to decide what action to take to support and protect the persons in question?**

8.3. There were eight different safeguarding concerns raised for Leah between March 2016 and November 2022 according to the mental health records. Three concerns were raised to a Section 42 inquiry, two being led by the long-term planning team in November 2021 and November 22, and one being led by LBC MASH in November 2022.

8.4. There were concerns recorded about Leah in Adult Social Care from 2019 and onwards. However, ASC did not know that the mental health services were not consistently as involved as thought from that period on. They also did not have a mechanism to check on progress of ongoing safeguarding enquiries being undertaken by ELFT under section 75 arrangements.

8.5. Assumptions were made about what each service was doing to support Leah and to address her needs. However, no MDT was held nor any communications between the agencies to confirm what was known and what each service was doing.

8.6. Leah was extremely vulnerable to abuse including sexual and financial abuse. She self-reported many incidents but there was little evidence that these were thoroughly followed up or resolved and dealt with through a robust multi-agency safeguarding enquiry.

- **Did practitioners demonstrate a good understanding of the lived experience and circumstances of Leah including her ethnicity and culture and if not, what were the barriers to this?**

8.7. Many different agencies were involved with Leah including primary care services through her GP as well as secondary and acute services through ELFT, LBC adult social care, LBC housing teams including rough sleeping, Luton & Dunstable Hospital, Bedfordshire Police and East Midland Ambulance Service. She also had involvement from LBC Neighbourhood Services and a number of independent housing providers who support those experiencing homelessness and complex housing needs.

8.8. Leah was described as having been independent with all her daily living activities. At the time of her death, Leah was living in an independent one-bedroom flat where she would have some support with housing, however, this was not specialist mental health supported accommodation. Her mental health was her main challenge but she had no clear diagnosis and when assessed she was said to have full capacity. Leah was noted to have made numerous allegations against other people and these were predominantly against males. In most of these episodes no supporting evidence could be found in relation to her allegations and they were often refuted by CCTV evidence.

8.9. Her needs were very complex. It appears that she had very complex mental health needs. However, there is a lack of consistency about the diagnosis of her mental health difficulties. The police have records concerning Leah going back to 1997 which identified her vulnerability. According to police records a mental health nurse told the police in 2021 that the diagnosis made of her mental health was that she had an emotionally unstable personality disorder with anxiety and depressive features.

8.10. An attempt to end her life in 2021 was recorded by the police as being her sixth attempt to do so. In 2022, it was suggested that she may be suffering from bipolar personality disorder. However, more recently it was stated CHMT psychiatrists had yet to make a formal diagnosis of her bipolar personality disorder. A difficulty had been that Leah did not engage with the services to receive a diagnosis. In June 2022, the consultant stated there was a great deal of ambiguity regarding her past presentation.

8.11. Leah's ethnicity and culture was not clear in agency records and there appeared to be little consideration of how ethnicity, diversity and inclusion may have impacted on her lived experiences. There was also insufficient consideration as to how Leah's culture, ethnicity and identify could have influenced her engagement with services and views about mental health problems.

- **Was the intervention provided timely or were there delays in responding, and if so, why?**

8.12. Leah had very significant mental health needs, was very vulnerable but could also be very challenging. Despite all these concerns and identified risks, she was placed in homeless accommodation without the high level of support she needed and the risks she posed to others as well as to herself. housing. The housing accommodation procedures did not sufficiently consider and therefore failed to meet Leah's needs as they did not ensure that a thorough assessment of her needs was made nor that her needs were appropriately matched to the placements provided.

8.13. Leah was discharged from the CMHT because of non-engagement, but due to an arson incident. she was taken back on by the CMHT. The responses to her needs were reactive rather than proactive and lacked an appropriate risk assessment process. Too readily her refusal to engage particularly with mental health services was accepted despite the risk she posed to herself and to others. Leah tended to be discharged back to the GP's care and this occurred on several occasions.

8.14. This was despite safeguarding concerns and arrests and no MDT meetings being called to share concerns and to plan together across agencies. Without her engagement mental health services were said not to able assess the risks which Leah posed. The homelessness department could have assessed her vulnerability and mental health issues to determine housing eligibility, but her behaviour and lack of engagement complicated these assessments. Overall, thresholds were applied based on available information and Leah's engagement,

but there were missed opportunities for more proactive and coordinated interventions.

- **Did practitioners fully consider whether Leah had "capacity" to manage her daily life and make decisions - based on having decision-making capacity - to keep herself safe?**

8.15. Leah had a history of mental health issues, including emotionally unstable personality disorder, mixed anxiety, and depressive disorder, but these were not formally diagnosed due to her inconsistent engagement with services. In March 2021, it was determined by ELFT CHMT in their assessments that Leah had full capacity and she did not require any mental health capacity assessment or DOLS interventions.

8.16. Leah was in the process of being assessed for bipolar personality disorder, but she never attended the second appointment required for a formal diagnosis. Additionally, a consultant in June 2022 questioned the validity of previous diagnoses, stating there was no formal diagnosis for her at that time. The next time assessment of mental capacity was mentioned was the night before her death when she was assessed as having capacity by the Street Triage Team.

8.17. Although Leah's mental health assessments indicated significant concerns there was no evidence that agencies other than ELFT considered her mental capacity. There were many occasions where practitioners could have considered her capacity due to her worrying behaviour but mental capacity assessments were seen as the remit of specialist services such as ELFT. UT did not appear to be understood that any practitioner can make a mental capacity assessment on simple specific decisions, such as whether she understood that her behaviour and presentation which was seen at times as risky and capricious could place her at risk of abuse and at best render her homeless.

- **Do practitioners know who they can turn to for expert advice and support in these areas if an adult is at risk but uncooperative and inconsistent in their engagement with services?**

8.18. The review indicated that there were gaps in communication and coordination among practitioners, which affected their ability to turn to the appropriate sources for advice. There were issues with handovers and communication between different agencies and teams, such as between MASH and Stockwood CMHT, which led to missed opportunities for coordinated support.

8.19. Practitioners highlighted the need for more responsive and effective escalation procedures when dealing with complex cases, suggesting that practitioners may not always know the best way to escalate concerns. They also highlighted the disjointed nature of systems and the need for better touchpoints to ensure information is shared and acted upon appropriately. This included the importance

of MDTs in managing complex cases, indicating that practitioners should turn to MDTs for advice and coordinated decision-making.

8.20. Overall, while there are mechanisms in place for practitioners to seek advice, the review suggests that improvements are needed in communication, coordination, and escalation procedures to ensure practitioners know where to turn for advice effectively.

- **How well does the commissioning function across the partnership facilitate identification or creation of accommodation-based support that can meet complex needs and how responsive is this to periods of crisis?**

8.21. The commissioning of accommodation-based support for Leah appears to have had significant shortcomings. As highlighted in the ANNA Integrated SAR/DHR there were several issues and recommendations regarding accommodation-based support for adults at risk of sexual exploitation and sexual abuse.

8.22. It highlighted there is a shortage of specialist accommodation for people with complex needs, particularly for women who have been or are being sexually exploited. The review suggests that more specialist resources are needed to provide higher levels of support and emphasises the need for coordinated holistic assessments and protection planning. It suggests that a 'team around the person' approach should be adopted to ensure that all relevant services work together to address the complex needs of individuals.

8.23. The ANNA review also makes the following relevant recommendations for Improvement which aim to improve the identification, support, and protection of adults at risk of sexual exploitation and abuse, ensuring they have access to safe and appropriate accommodation and wrap-around support services.

- **Revise Local Policy Framework**: The Partnership Boards should revise the local policy framework for responding to adult sexual exploitation, ensuring clarity in risk management processes and accountability for actions to mitigate abuse.
- **Trauma-Informed Training**: Local Authority and ICB commissioners should arrange bespoke trauma-informed cross-disciplinary training for staff working with adults experiencing sexual exploitation and abuse.
- **Safe Havens**: The development of physical safe havens in Luton, such as GP surgeries and women-only drop-ins, where individuals at risk can access immediate, wrap-around support and safe accommodation.
- **Housing Allocations Policy**: Amend the local housing allocations policy to make explicit that victims at risk of sexual exploitation threatened with homelessness are in priority need.

8.24. These recommendations and findings are reflective in regard to Leah as the accommodation provided to Leah did not meet her complex mental health needs. The housing provider offered support to prevent homelessness but was low support housing, which by definition, lacked specialist mental health support, which was crucial for Leah.

8.25. Overall, the commissioning of accommodation-based support for Leah did not work well due to inadequate risk assessment, lack of specialist support, poor communication, and missed opportunities for coordinated interventions. Improvements are needed in these areas to ensure that vulnerable individuals receive appropriate and effective support.

- **How does local availability of resources impact on care planning and safeguarding?**

8.26. As referenced in the sections above there is a lack of accommodation based support provision for those with complex mental health needs. This manifested itself in issues with risk assessment and escalation procedures. The housing provider did not fully understand Leah's mental health needs, leading to inadequate support to assess her mental capacity and manage her behaviour.

8.27. There were gaps in communication between agencies, such as between the housing provider, mental health services, and social care. This disjointed approach affected the effectiveness of the support provided. Practitioners identified missed opportunities for more proactive interventions and better coordination among agencies. The lack of a multi-disciplinary team (MDT) approach and poor handovers contributed to the ineffective support.

8.28. Practitioners did not have access to thresholds guidance that supported their decision making by making clear the types of support available for adults with complex care and support needs that need a safeguarding response.

9. Findings:

9.1. The inquest determined that Leah was an adult with significant mental health issues which led on occasion to her chaotic lifestyle. Leah had five previous episodes of suicidality and due to her precarious mental health issues she would be likely to act on her suicidal impulses. Unfortunately, Leah’s already fragile mental state was exacerbated by the impending threat of eviction in mid-November 2022, which contributed to her taking her own life.

9.2. There is considerable additional learning from this review of the circumstances of Leah and the service responses to her. As highlighted above Leah was living a chaotic, disordered lifestyle towards the end of her life. The service responses to her needs were ineffective and lacked the appropriate level of risk assessment, planning, and review which was required to engender trust and interrupt and resolve the chaotic lifestyle which had developed.

9.3. The complexity of Leah’s needs, including high-risk behaviours and serious self-harming episodes, was not sufficiently fully appreciated or shared across agencies. An overly optimistic view was taken of the risks her behaviours posed to herself and others and of the risks from others to her. There was little evidence in the records of consideration of Equality, Diversity and Inclusion issues as they presented in Leah’s circumstances. The intersectional relationship

between the range of issues and the needs for Leah were not fully considered. **This manifested itself in:**

- **Absence of required Comprehensive Multi-Agency Assessments:**

9.4. There was a need for more comprehensive and multi-agency assessments to ensure all aspects of Leah's needs and vulnerabilities were considered and addressed together, including accommodation, mental health, physical needs, challenging behaviours, and any risks posed to herself and others.

- **Challenges with Engagement:**

9.5. Services found it difficult to engage Leah and she found it difficult to trust those working with her. When Leah did not engage with services offered, this was not fully tested out and services tended to desist from further action to support her and deferred her care back to the GP often advising her to make contact with them herself. This left the GP outside of multi-agency information sharing.

- **Inappropriate Accommodation and Support Services:**

9.6. The general accommodation for homelessness provided to Leah did not meet her complex mental health needs, contributing to her tragic outcome and Leah was placed in homeless accommodation lacking specialist mental health support. The housing providers were not set up to conduct thorough assessments of her needs and consider her fluctuating capacity. Sometimes safeguarding referrals or share multi-agency intelligence were not shared when policy and procedure appeared to require it.

- **Ineffective multi-agency working:**

9.7. There was an absence of multi-agency review and planning often appeared to be interagency i.e. between two agencies or in silo rather than through planned multi-disciplinary meeting. For example, joint working across mental health and adult social care was not sufficiently effective to address the needs of high risk, vulnerable adults who are not engaging consistently with services. While ELFT are commissioned to provide social work support there was insufficient liaison between the two agencies who had responsibility for assessing her care and support needs and tracking of the ongoing risks and needs.

- **Lack of multi-agency working / clear safeguarding plans:**

9.8. There did not appear to be shared effective intervention plans and risk management was often undertaken in isolation. In Leah's case, a much more sophisticated consideration of all the risks and vulnerabilities she posed and to which she was exposed was required.

- **Lack of professional curiosity and questioning:**

9.9. Agencies failed to comprehensively consider how her complex factors intersected and influenced her lived experience. For example, Leah's complex needs, including high-risk behaviours and previous serious self-harming episodes, were not sufficiently shared across agencies, and an overly optimistic view was taken of the risks she faced. There was a lack of professional curiosity and questioning about how EDI issues impacted her circumstances.

- **Lack of systematic and regular monitoring and MDT review:**

9.10. The planning and assessment for Leah would have benefited from regular MDT meetings pulling in all agencies who were trying to support Leah and a clear plan of action for Leah when she disengaged. It was telling that the first MDT meeting for Leah took place after her tragic death. Leah would have benefited from being reviewed under a high-risk complex pathway.

- **Multi-Agency Coordination and Communication Failures**

9.11. The lack of effective communication and coordination among agencies significantly impacted Leah's care. There were gaps in communication between mental health services, social care, and housing providers. No multi-agency meetings were held to discuss Leah's case, leading to isolated responses.

- **Reactive Rather Than Proactive Responses:**

9.12. Responses to Leah's behaviour and vulnerability tended to be reactive rather than planned, solution-focused, and proactively geared to improve outcomes for her. There was a lack of coordination of activities across agencies and she lacked clear, consistent key worker arrangements that would have supported her engagement and building of trust.

10. Learning / Recommendations and suggested Actions

10.1. Based on the findings, the following recommendations are proposed to enhance practice:

1. Strengthen Multi-Agency Collaboration

- Establish regular Multi-Disciplinary Team (MDT) meetings for high-risk cases to ensure coordinated planning and information sharing.
- Improve communication and handovers between agencies to avoid gaps in care and support.

2. Enhance Risk Assessment and Planning

- Develop clear guidance on thresholds for intervention, particularly for adults with complex needs, dual diagnoses, and self-neglect.
- Ensure comprehensive, multi-agency risk assessments are conducted and regularly reviewed.

3. Improve Housing Support for Complex Needs

- Commission specialist accommodation with mental health support for individuals with complex needs.
- Revise housing allocation policies to prioritize individuals at risk of exploitation or abuse.

4. Increase Professional Training

- Provide trauma-informed training for practitioners to better understand and respond to the needs of individuals with complex mental health issues.

- Train practitioners on conducting mental capacity assessments and recognizing when they are necessary.

5. Foster Proactive and Preventative Approaches

- Shift from reactive responses to proactive, solution-focused interventions that address underlying issues.
- Implement a "team around the person" approach to ensure holistic and coordinated care.

6. Improve Safeguarding Enquiries

- Ensure safeguarding enquiries under Section 42 are robust, with clear accountability and follow-up actions.
- Address assumptions about agency responsibilities and ensure clarity on roles in safeguarding processes.

7. Develop Clear Escalation Procedures

- Create clear pathways for practitioners to escalate concerns and seek expert advice when dealing with uncooperative or high-risk individuals.

8. Address Equality, Diversity, and Inclusion (EDI)

- Systematically consider EDI issues in assessments and interventions, recognizing the intersectionality of factors affecting individuals.

9. Monitor and Evaluate Practice Improvements

- Regularly review the impact of changes in policies, procedures, and practices through audits and assurance events.
- Continue to use findings from SARs to inform continuous learning and improvement across agencies.

10. Expand Safe Havens and Support Services

- Develop physical safe havens, such as women-only drop-ins, where vulnerable individuals can access immediate support.
- Ensure wrap-around services are available to address the full spectrum of needs, including mental health, housing, and safeguarding.

10.2. By implementing these recommendations, agencies can better safeguard vulnerable adults, improve outcomes, and prevent similar tragedies in the future.

10.3. The Learning from SARs days held at the end of November 2023 and in March 2025, were able to evidence practice improvements made locally over the preceding few years and to set targets for further improvement. The aim was to assess what had been the impact of such learning on policies, procedures and practice to protect vulnerable individuals within the community. Evidence of progress is set out below:

10.4. There is evidence that assessments are being completed to understand the complexity of circumstances like Leah's through the Luton Critical Adult Safeguarding Partnership Arrangements (CASPA)7 process. The CASPA, a high-risk complex case group is now in place which consistently and regularly reviews and monitors events and responses in cases like Leah on a multi-agency basis. There is evidence of more joined up working between individual agencies to consider risks to and from individuals like Leah.

10.5. As well as CASPA guidance on a framework for a shared understanding of safeguarding concerns has been shared widely. The Adult Social Care workforce is more equipped in dealing with victims of sexual exploitation and domestic abuse and are able to respond quickly. There is progress in having a domestic abuse pathway, and a Public Health vulnerable women's pathway.

10.6. The impact of Adult Anna's SAR has been an improvement in collaborative working, improved support pathways for clients, agencies now more familiar with their responsibilities, and more staff seeking advice. In addition, there has been more trauma awareness from staff, also in relation to more awareness to prevent re-traumatising service users.

10.7. The On Street Sexual Exploitation Strategy was completed, and a Complex Case Co-ordinator will be employed which this will improve the co-ordination of support. A gap was identified as domestic abuse is a priority need for housing, but sexual exploitation is not.

10.8. LSAB has added Rough sleeping to its governance structure and workstreams, in line with the mandate from the government. There have been rough sleeping workshops, to aid the partnership, and the Service Director of Housing is now a member of the Board. In addition, there is an LBC Rough Sleeping Co-ordination manager and outputs reported to the Board quarterly. There are several new initiatives including commissioning specialist services, street outreach and a more multi-disciplinary response.

10.9. Due to the introduction of accommodation-based support, there has been a decline in numbers of new rough sleepers per quarter. In addition, there is a strong partnership early intervention approach, including mental health support. Although auditing data shows that there appears to be a small improvement in the quality of Mental Capacity Assessment, although application of policy is still an area of development and there will be ongoing training to support this need.

10.10. Anyone threatened with homelessness is prioritised within the allocations policy when a duty decision is made. Housing is creative with their solutions to homelessness and rough sleeping and the offer for individuals. A case study of a women rough sleeping for 17 years outside the train station was provided and how she had been supported on her own terms this was good evidence of making safeguarding personal. It was noted that some of the barriers for housing

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[7] https://trixcms.trixonline.co.uk/api/assets/panbedfordshiresabs/82261717-4e22-4a7f-8f06-6c4a7ae625af/caspa-tor-feb-2024.doc

solutions are due to national housing legislation. The LSAB need to consider how they can influence this.

10.11. There is some evidence that Equalities, Diversity and Inclusion (EDI) issues are being more systematically considered through revised policy and procedure. There are some improvements in gaining and analysing data in relation to Ethnicity in referrals, reports and practice. However, there is more that needs to be done in this space and this work needs to gather pace.

APPENDICES

Appendix A

The Care Act 2014 and Adult Safeguarding Duties

- Care Act statutory guidance 2014 formally recognises self-neglect as a category of abuse and neglect – and within that category identifies hoarding.
- This enables local authorities to provide a safeguarding response, including the duty to share information for safeguarding purposes; the duty to make enquiries (S42) and the duty to provide advocacy, where a person has no one to advocate on their behalf.

Safeguarding duties apply to:

- any adult who has care and support needs (whether or not the local authority is meeting any of those needs); and
- is experiencing, or at risk of abuse and neglect (including self-neglect); and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect.

The duties apply equally whether a person lacks mental capacity or not. So, while an individual's wishes and feelings are central to their care and support, agencies must share information with the local authority for initial enquiries to take place.

Enquiries may take place even when the person has capacity and does not wish information to be shared, to ensure abuse and neglect is not affecting others, that a crime has not been committed, or that the person is making an autonomous decision and is not being coerced or harassed into that decision. Safeguarding duties have a legal effect in relation to many organisations and the local authority may request organisations to make further enquiries on their behalf.

The purpose of a safeguarding enquiry (S42) is initially for the local authority to clarify matters and then decide on the course of action to:

- Prevent abuse and neglect from occurring
- Reduce the risk of abuse and neglect
- Safeguard in a way that promotes physical and mental wellbeing
- Promote choice, autonomy and control of decision making
- Consider the individual's wishes, expectations, values and outcomes
- Consider the risks to others
- Consider any potential crime
- Consider any issues of public interest
- Provide information, support and guidance to individuals and organisations
- Ensure that people can recognise abuse and neglect and then raise a concern
- Prevent abuse / neglect from re-occurring
- Fill in the gaps in knowledge
- Coordinate approaches
- Ensure that preventative measures are in place
- Co-ordinate multi agency assessments and responses

Appendix B

Safeguarding Adult Reviews (SAR) National Requirements

The Care Act 2014 came into effect from 1st April 2015. Under section 44:

“(1) A Safeguarding Adults Board 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 Safeguarding Adults Board, 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 Safeguarding Adults Board 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 Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

(4) A Safeguarding Adults Board 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).

(5) Each member of the Safeguarding Adults Board must co-operate in and contribute to the carrying out of a review under this section with a view to:
(a) identifying the lessons to be learnt from the adult’s case, and
(b) applying those lessons to future cases.”

The Care Act 2014 Guidance explains that the purpose of a review is to:

i. Develop learning that enables the safeguarding adults' partnership future.
ii. Ensure that lessons are learnt and lessons are applied to future situations to improve local practice, procedures and services together with partnership working to minimise the possibility of circumstances similar to this happening again.
iii. The purpose of the review is not to apportion blame or hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission, the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

The following principles apply to all reviews:

- there must be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews must be proportionate according to the scale and level of complexity of the issues being examined;
- the individual (where able) and their families will be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively;
- the Safeguarding Adults Board is responsible for the review and must assure themselves that it takes place in a timely manner and appropriate action is taken to secure improvement in practices;
- reviews of serious cases will be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed and
- Professionals/practitioners will be involved fully in reviews and invited to share their perspectives.

Appendix C
Summary of Key Events in Leah**'s Life 2021- 2022**

The following events highlight the significant incidents and interactions involving Leah, reflecting her complex needs and the challenges she faced.

1. **October 2021:** Leah lit an envelope, setting off a smoke detector and fire alarm in her building. This led to a safeguarding referral and section 42 enquiries.

2. **February 2022:** Leah set fire to another resident's property and reported a domestic abuse incident involving her son. She was arrested for arson, assessed by the ELFT Community Mental Health Team, and referred to various services. This ultimately led to LBC Neighbour Services obtaining an injunction against Leah which meant she could no longer live at her son's property and which in effect made homeless.

3. **March 2022:** Leah breached her court order not to visit her son's flat, leading to a report of domestic assault, kidnap, and threats. She was placed in temporary accommodation and later given a suspended custodial sentence for breaching the court order.

4. **May 2022:** Leah alleged sexual harassment by another resident at Signpost Housing. Staff assured her safety but did not report the matter to the police or make a referral to Adult Social Care.

5. **June 2022:** Leah reported feeling unsafe due to accusations from other residents. She also made allegations of racism and drug-related activities.

6. **August 2022:** Leah was found sleeping in another resident's room and reported drug-related activities and threats. She was moved to alternative accommodation and made a homeless application.

7. **September 2022:** Leah reported being in a 'dark place' and having fleeting thoughts of suicide. She was assessed by the ambulance and Mental Health Street Triage and referred back to the ELFT CMHT.

8. **October 2022:** Leah reported a male using crack cocaine and threatening her with sexual assault. She also reported a verbal argument with her son and was conveyed to the hospital for a medical condition.

9. **November 2022:** Leah reported harassment and financial abuse by a neighbour. After stealing a laptop from the CCHM office which she later returned she contacted the ELFT Mental Health Community Liaison worker about feeling suicidal and was assessed by police and ambulance services. Leah believed she would be evicted and threatened CCHM staff she would take her own life. CCHM were unable to access her flat and after gaining forced entry she was found deceased in her flat the following day.

Appendix E: Abbreviations

ASC – Adult Social Care
CCHM - Creative Change Housing Management
CMHT - Community Mental Health Team (ELFT)
CRHT - Crisis Home Resolution and Home Treatment (ELFT)
ELFT – East London Foundation Trust
LBC – Luton Borough Council
LHR – Luton Hotel Residence
MDT – Multidisciplinary Team
PHP - Personal Housing Plan
SAR – Safeguarding Adults Review

Appendix F: References

Bedfordshire Safeguarding Adults Policy and Procedures
https://panbedfordshiresabs.trixonline.co.uk/

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https://www.local.gov.uk/understanding-what-constitutes-safeguarding-concern-faqs

Luton Multiagency adult safeguarding procedures (2017)
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