Safeguarding Adults Review

‘Patsy’

Executive Summary

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1 Patsy's Life, Her Death, and the Delayed Discovery of Her Death

1.1 This Safeguarding Adults Review [SAR] relates to a woman, Patsy, who was found dead in 2021. Subject to the findings of the Coroner's Inquest, this is likely to have been some three or more years after she passed away.

1.2 Patsy is a name that the woman sometimes used as her preferred name.

1.3 Patsy was a single white woman in her late thirties. She lived alone in her flat as a tenant of Woking Borough Council.

1.4 The purpose of this SAR is not to re-investigate or to apportion blame, nor to establish how Patsy died. Determining how, where and when Patsy died is the responsibility of the Coroner through an Inquest.[1]

1.5 In March 2023, the Surrey Safeguarding Adults Board decided to commission a Safeguarding Adults Review [SAR], to review:

- the circumstances of the care and support that Patsy had received in the years before her death, and
- how it came about that her death was not discovered for over three years.

1.6 Patsy's family have experienced deep sorrow and distress at what unfolded in Patsy's life and the circumstances of her death and how it was discovered.

1.7 This Safeguarding Adults Review is clear from the accounts that her family have given, that they were frequently and consistently rebuffed by Patsy, and that they accepted Patsy's autonomy in deciding to live her life as she chose.

1.8 The review has not found anything that suggests that there were actions that family members could have taken that might have changed the course of events. Patsy was determined to exclude her family from her life, and her decisions to do so were respected by them.

1.9 Following her death, Patsy's family have shown courage and determination to ensure that lessons are learned from what happened to her.

1.10 The SAR has found that there were many missed opportunities where, if services had intervened differently, Patsy's inability to engage with others in relation to her distress and withdrawal might have been helped.

1.11 Patsy was born with a rare congenital condition known as Goldenhar Syndrome[2]. Goldenhar Syndrome is an umbrella term for a range of changes that happen to an unborn baby's face and body development in the first three months of pregnancy. The cause is believed to be an abnormality in a chromosome. It is not usually an inherited disorder. Each person with Goldenhar Syndrome is affected differently.

1.12 Patsy had profound hearing difficulties. Patsy's body wasn't symmetrical, and this affected the shape of her spine, one of her arms and one of her hands. Her face and

[1] More information about the role of the Coroner and inquests can be found at https://coronerscourtssupportservice.org.uk/

[2] You can read more about Goldenhar Syndrome at https://www.goldenhar.org.uk/

ears were also a little asymmetrical. When she was 18, she had open heart surgery to repair a hole in her heart.

1.13 Throughout all her life Patsy had claimed and been entitled to various welfare benefits including Attendance Allowance (as a child), Severe Disability Allowance, Employment Support Allowance, and Disability Living Allowance [DLA]. When she was a tenant of Woking Borough Council, she received Housing Benefit and Council Tax relief.

1.14 While using the services of Surrey and Borders Partnership NHS Foundation Trust [the Trust] from 2006 to 2010, Patsy was diagnosed with Persistent Delusional Disorder. Patsy's records also indicate that at times she experienced depression.[3]

1.15 Delusional disorders are a form of psychosis. The literature does not indicate any evidence of an association between Goldenhar Syndrome and psychosis.

1.16 Delusional disorders take many forms. Untreated delusional disorders are known to lead some people to withdraw from the world around them, experience social isolation and potentially neglect their own self-care. With the benefit of hindsight, the SAR has found that this was Patsy's experience.

1.17 Patsy had two episodes of detention for in-patient assessment under the Mental Health Act, first in 2006 and then in 2009, and follow up from community mental health services. She was never detained under a treatment order. Opportunities to involve Patsy's family in decisions about her care were foregone in the context of Patsy's wish to distance herself from them.

1.18 Throughout her contact with services Patsy made several assertions about traumatic events in her childhood. Sometimes her statements were taken at face value, at other times there seems to have been a working assumption by mental health services that her preoccupations were a manifestation of her delusional disorder. This background compounded the exclusion of Patsy's family from her care.

1.19 Patsy was discharged from secondary mental health services in the Trust in 2010.

1.20 Other than discharging her care to her GP, Patsy was not provided with a care plan or a crisis plan.[4] No offers of advocacy support, including peer-advocacy, were made to Patsy when she was discharged from mental health services.

1.21 As she had been homeless when she left hospital in 2006, Woking Borough Council provided Patsy with temporary accommodation. The circumstances of Patsy's need for housing (her mental distress, and needs arising from her Goldenhar Syndrome) were addressed in her referral from mental health services to Woking Borough Council.

[3] During one of the inquest hearings (October 2024), it came to light that in a letter sent from the Trust to Patsy's GP in April 2010 her diagnosis was recorded as "Persistent Delusion Disorder (Provisional) [No current symptoms]. When she was discharged from the Trust's care her then current diagnosis was recorded as "Previous and Delusional Disorder", noting that she was currently well.

[4] Following information disclosed in the October 2024 inquest hearing, the review author asked for Trust records to be re-checked. Records indicate that copies of letters to Patsy's GP were sent to Patsy. However, there is no mention in the records of Patsy being provided with personal written plans.

1.22 In the Spring of 2007 Patsy moved to her flat on the Sheerwater Estate in Woking. Her landlord was Woking Borough Council. Between 2012 and 2022, New Vision Homes were the managing agent for Woking Borough Council housing.

1.23 It could have been possible for Patsy's housing record to have had a flag identifying her as having some additional needs as a tenant (because of her hearing needs or her mental ill health). It is not known whether such a flag appeared on Patsy's records at this time, as these records are no longer available following the transfer of old records to a new electronic record system in 2019.

1.24 If there was no flag on her former records, then the possibility of her landlord being alerted to Patsy's additional needs was missed.

1.25 In 2010 Patsy began emailing a clergyman regularly, escalating to a point in later years where he was receiving multiple emails from her per day. The clergyman's email address was publicly available. Patsy had attended two services where he had officiated, but she did not know him personally.

1.26 In 2013 Patsy stopped claiming Employment Support Allowance. She fell into rent and Council Tax arrears and had received an eviction notice in 2014. In the process of addressing her arrears, she received support from Woking Borough Council's Floating Support Team. The worker who saw Patsy was concerned about Patsy's mental state and made referrals to both the Trust's Community Mental Health service and Patsy's GP.

1.27 Patsy's Housing Benefit arrears were paid by a friend, and her Council Tax arrears were also paid, though it is unclear by whom.

1.28 Patsy's GP practice took the lead to follow up the Floating Support referral, and asked Patsy to attend an appointment. Patsy advised the practice that she was changing her GP practice to one that was nearer to her home.

1.29 She then did not register at the new practice for several months. She attended the new practice once to register as a new patient; the process which would trigger the subsequent transfer of the records from the first practice. As she did not attend the second practice ever again, the record of her mental health referral was not seen by the new practice.

1.30 In 2013 the Department of Work and Pensions [DWP] had introduced a new benefit, Personal Independence Payments [PIP]. People, such as Patsy, who had previously received Disability Living Allowance [DLA] needed to be reassessed for PIP.

1.31 Patsy's family have confirmed that the Department of Work and Pensions sent several letters to Patsy at the beginning of 2016 advising her that she needed to apply for PIP. Patsy's DLA came to an end in March 2016.

1.32 All the evidence available to the review indicates that Patsy did not apply for PIP. She advised the Council that she would not apply as she could "*not cope with the invasive medical check-up*" it would involve.

1.33 In March 2017 Patsy's total net capital was sufficient to sustain her usual expenditure (as determined in her Council assessment) for over a year.

1.34 With the benefit of being able to see a fuller picture with hindsight, the SAR has found that Patsy's mental and psychological state had the following characteristics in the autumn of 2017:

- Patsy was living on her savings as she had not made an application for PIP because as she told Woking Borough Council, she could "*not cope with the invasive medical check-up".* Her entitlement to Employment Support Allowance had also lapsed.
- Patsy found the outside world frightening and oppressive. This led her to remaining indoors with no known contact with any others either in her stairwell, or in the wider world.
- She found engaging with people very psychologically challenging.
- She had distanced herself from her immediate family for some time and had no contact with them.
- She was arranging most of her shopping via a supermarket home delivery.
- She had not gone into a high-street bank in person to begin the process of setting up the arrangements to withdraw cash from a savings account. We can surmise that this was because it would involve engaging in a face-to-face encounter where she would have to identify herself, something she feared deeply.
- She did not respond to requests from her GP surgery to attend for screening appointments.
- Sometimes Patsy's eating patterns were such that she ate little. As access to money was beginning to run out it does appear that this pattern might have been active once again.
- She maintained an extensive one-sided email correspondence with a clergyman she had only encountered twice briefly at a service several years earlier.
- She made a few notes about how she felt in her diary. There is a little more detail in drafts of a letter she sent to the clergyman.
- Despite money in the bank, and likely eligibility for Employment Support Allowance and PIP, as Patsy's *access* to money ran out and her phone stopped working, she did not reach out for any help, other than mentioning her situation in her correspondence to the clergyman.

1.35 If we understand Patsy to be experiencing a delusional disorder, which is the diagnosis reached by mental health services, then her behaviours are consistent with the symptoms associated with such a diagnosis; the compulsive correspondence with someone with whom she did not have any relationship and the negative symptoms of extreme withdrawal and social isolation leading to self-neglect. Some of this might well have been compounded by experiences of growing up living with a syndrome that brought additional challenges.

1.36 Patsy's mental health records are silent on any thought being given to Patsy's executive functioning. We can infer from what we know with hindsight, that Patsy's delusional disorder had an impact on her ability to make decisions about her wellbeing and welfare. That meant that consideration should have been given to her decision-making capacity and her executive functioning within the terms of the Mental Capacity Act 2005, its Code of Practice and practice guidance. What is meant by executive capacity in this context is Patsy's ability to plan and act to support her need for income, the wherewithal to respond to her nutritional needs, and her needs for socialisation with others which would include the mutual support that can come with friendship.

1.37 In September 2017 Patsy wrote a letter to the clergyman she had been emailing for several years. For the first time since Patsy had been writing to him, he decided to contact the police.

1.38 On 7 October 2017 a police officer visited Patsy and asked her to desist from writing to the clergyman. She readily agreed to do so. The police officer knew she had a history of mental illness and asked about her welfare. All she disclosed was that she was short of money and food, and he provided her with details of a local food bank that might be able to support her. She displayed no signs of overt mental illness to the police on this visit and both she and her flat presented as clean and tidy.

1.39 The police submitted what was then known as a 39/24 request, now known as a Single Combined Assessment of Risk Form [SCARF][5], to share information about Patsy's vulnerability due to her shortage of money and food.

1.40 This alert was graded as an amber risk and processed by the Multi-Agency Safeguarding Hub [MASH] and sent as an adult at risk referral to the adult social care team on 13 October 2017. The form was marked for awareness of vulnerability, learning difficulties, observation of circumstances and neglect / acts or omission.

1.41 The adult at risk referral from the police mentions that Patsy did not have a lot of money or food and did not have access to services that will be able to help her. A record made by the adult social care team on 18 October 2017 noted that the police adult at risk form was added to the system as a contact and that previous case files and case notes should be referred to.

1.42 On 19 October 2017, an Adult Social Care Duty worker wrote a letter to Patsy, noting that they could not contact her by phone and giving her information about local food banks and the Citizens' Advice Bureau. Information about food banks had already been given to her by the police. The letter also invited her to make contact if she needed any further assistance.

1.43 Patsy's circumstances were not progressed within Adult Social Care for assessment of her needs. On 2 November 2017 a file entry was made closing the case as no response had been received to their letter.

1.44 All the evidence available suggests Patsy's last food shop took place via a Tesco delivery on 4 September 2017, and she recorded on her calendar against that day that she had no money. Evidence found by her family suggests that Patsy's phone was disconnected by her provider during this period when she no longer had funds for the monthly direct debit.

1.45 Patsy had a wall calendar on which she marked off the days as they passed. The last day marked off is the 1 of November 2017.

1.46 During 2018 to 2021, Patsy's Housing Benefit and Council Tax continued to be paid. Since Patsy had advised them that she would not be claiming benefits, they had not received any notifications about any changes in her circumstances. The DWP had ceased the requirement for annual reviews in 2012/13.

1.47 Patsy's property was subject to annual gas checks. In January 2018 a gas safety certificate was issued for her property. For this to be issued lawfully it would have meant that a gas engineer had entered her property. The validity and the issuing of this certificate is a matter which the Coroner will consider when Patsy's inquest takes place.

[5] https://www.surrey.police.uk/SysSiteAssets/foi-media/surrey/policies/scarf---vulnerable-adult-referral-form-submission-procedure.pdf

1.48 In 2019 a different gas safety contractor's engineer capped off the external gas supply to Patsy's flat, having not been able to gain access. In 2020 and 2021 the same new contractor company attempted to gain access to Patsy's flat but were unable to. No action was taken to ensure that the landlord followed up on the lack of access to Patsy's flat.

1.49 Patsy's home formed part of a large-scale regeneration project. Patsy had been informed of this and had been preparing to move.

1.50 In the months and years following the likely timing of her death, other residents, and tenants in the stairwell where she lived began to move out.

1.51 In late March 2020 the country went into lockdown in response to the Covid pandemic. Health, social care and housing agencies immediately began programmes to identify people at additional risk and provide them with necessary support.

1.52 In terms of her health conditions, Patsy did not meet the health-related criteria for Covid health intervention and support afforded to people who were deemed to be clinically vulnerable.

1.53 Woking Borough Council did put in place an extensive programme to identify and support vulnerable tenants. However, Patsy's electronic housing record did not flag her additional needs and therefore no attempts were made to ascertain how she was managing with lockdown.

1.54 From the autumn of 2020 Patsy's flat was the only flat in her stairwell that continued to be occupied (albeit, subject to the findings of the Inquest it is likely that Patsy had by then sadly died).

1.55 Patsy's father died in March 2021 following a period of ill health. In the months before his death family members dropped by Patsy's flat to let her know he was unwell. There was no response at her front door. When Patsy's father died, a member of Patsy's family tried to visit her to let her know. They could see that there was post piled up behind the door. They were concerned for her. They wondered if she had been admitted to a mental health ward or might be with friends. They phoned local hospitals to check if she had been admitted. They alerted Woking Borough Council's Regeneration support team who passed on the concern to New Vision Homes. It is not clear what action if any was taken by New Vision Homes.

1.56 In May 2021 a member of Patsy's family returned to her flat and this time pushed the brushes on the letter box back fully. They were then able to see what appeared to be a body in the flat. They contacted the emergency services. When the police entered the property, they found Patsy's dead body. The decomposed condition of her body was such that she had been dead for some time.

1.57 These tragic circumstances meant that Patsy's death was referred by the Police to the Coroner and would become the subject of a Coroner's Inquest. A first pre-Inquest hearing was held in November 2022; there have been subsequent pre-Inquest hearings pending a full Inquest.

1.58 Although the fact of Patsy's death was communicated to her landlord immediately, the review has found that it is likely that no one who knew of the circumstances of Patsy's death shared this information with her landlord in the aftermath of her death.

1.59 Patsy's family were issued with an end of tenancy letter. Faced with this letter, the family undertook to clear Patsy's flat rapidly. This included dealing personally, without any expert practical assistance, with the task of cleaning a flat where their loved one's body had been decaying for many months. In addition to everything else that has happened, this remains a source of great distress for Patsy's family.

2 Changes to Practice

2.1 Since the sad circumstances of Patsy's death, agencies have responded with a number of changes in practice:

Church of England

2.2 Since 2017, there have been significant developments in safeguarding policy and practice within the Church. Specifically, there is now a new combined practice guidance in relation to responding to safeguarding concerns about children and vulnerable adults, which was published in November 2018[6].

2.3 In recent years, safeguarding training has also developed and improved in the Church of England, which greater inclusion of challenging case studies related to vulnerable adults. Within the Diocese where the clergyman who received the emails from Patsy resides, specifically, Mental Health First Aid training has been offered to clergy and other relevant church officers since 2021. This has led to an increase in contact with the Diocesan Safeguarding Team in relation to concerns about adults and their mental health.

2.4 From a wider safeguarding perspective, the development of a Safeguarding Standards & Quality Assurance Framework[7] in 2023 is adding greater emphasis on striving for good safeguarding practice in all areas of Church life and interactions clergy and other church officers have with children and adults. The standards sit within the wider suite of policy and practice guidance documents.[8]

Department of Work and Pensions [DWP]

2.5 DWP is committed to ensuring that it gives claimants the right support at the right time and are constantly reviewing the services they provide in an effort to improve for all customers, especially the many vulnerable people who rely on them. Since the time when Patsy did not apply for PIP, the DWP has developed stronger process to signpost vulnerable claimants to third party support including agencies that can help with needs for safeguarding. These measures include:

2.6 More than 35 Advanced Customer Support Senior Leaders (ACSSLs - previously known as Senior Safeguarding Leaders) have now been appointed across Great Britain.

2.7 DWP has also created central teams in the Customer Experience Directorate to focus on strategically supporting their most vulnerable customers.

2.8 Every Jobcentre has a complex needs toolkit containing links to local organisations who can help and provide appropriate support to those who require it.

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[6] https://www.churchofengland.org/sites/default/files/2018-11/responding-to-safeguarding-concerns-or-allegations-that-relate-to-children-young-people-and-vulnerable-adults.pdf

[7] https://www.churchofengland.org/sites/default/files/2023-10/national-safeguarding-standards-and-quality-assurance-framework_sep23.pdf

[8] https://www.churchofengland.org/safeguarding/safeguarding-e-manual

2.9 The DWP has a detailed mental health training package which includes modules on appropriate actions to take to support customers with vulnerabilities such as mental health issues. This training is delivered to all customer facing staff, to provide colleagues with learning that they can then apply in different scenarios with which they may be faced.

2.10 In September 2019 the DWP established a Serious Case Panel to help the Department learn lessons and address systemic issues arising in serious cases, Internal Process Reviews and other sources. It makes recommendations to address systemic issues and monitors and tracks their progress.

2.11 In late 2020 the DWP established an Internal Process Review Group [IPRG] to ensure that lessons learned from IPR's are taken forward to inform future policy and service. The group was established to increase oversight of IPR's at a more senior level. Key themes and systemic issues identified by the IPR Group feed into wider Customer Experience improvement activity.

Surrey and Borders Partnership NHS Foundation Trust [the Trust]

2.12 The Trust acknowledge that various safeguarding concerns including Patsy's allegations about childhood trauma and her safety in the community should have been investigated. This had the potential to address Patsy's ongoing safeguarding as well as evaluating any risks to any others.

2.13 In April 2018 an addendum to a key policy was made which provides expectations and guidance to staff about actions needed when disclosures of historical events are made. As part of the Trust's developing practice, they now have a Safeguarding Lead and an Advanced Practitioner who provide advice on actions that staff can take when patients raise issues about historical events in their lives.

2.14 The Trust also acknowledge that the Patsy's additional disabilities did not feature sufficiently in their planning for her needs. They recognise that advocacy, including peer advocacy/support, could have been of benefit to Patsy in relation to her engagement with services and development of coping skills. The Trust now have access to two different Advocacy providers and there is clear information available for all staff about these services and when and how to refer to them. There are monthly audits of records in relation to consideration of advocacy and analysis discussed at monthly Quality Assurance Groups to inform feedback to staff and training.

2.15 They regret that opportunities were not taken to consider how best to involve Patsy's family in the plans for Patsy's care in the community. The Trust now have a Carers' Charter and monitor their compliance with the Charter by training staff to be carer aware, seeking the views of carers, and consistently implementing the Triangle of Care standard[9]. This monitoring includes monthly audits of records and analysis discussed at monthly Quality Assurance Groups to inform feedback to staff and training. The Trust currently holds the highest accreditation achievable for a Mental Health Trust in the Triangle of Care, awarded by the Carers Trust.

2.16 Although there were plans outlined in progress notes in Patsy's records, there were no formal Care Plans developed with Patsy. A Care Planning Improvement Steering Group is in place at the Trust and the Care Planning Principles for Trust Policy was agreed in

[9] https://carers.org/triangle-of-care/the-triangle-of-care

August 2023. This provides clear guidance regarding expectations that care plans are person centred, co-produced and regularly reviewed. This relates to all types of care plans, including safety and crisis plans. The Care Programme Approach (CPA) Policy has been in place since February 2018 which includes information relating to expectations post hospital discharge and the important role of carers in the process. Monthly audits of records relating to care planning is undertaken and analysis discussed at monthly Quality Assurance Groups to inform feedback to staff and training.

2.17 The Trust's Care Programme Approach (CPA) Policy in place since February 2018 includes information relating to expectation post hospital discharge and the important role of carers in the process. This addresses the need for Crisis plans to be developed and implemented with patients.

2.18 At the time that Woking Borough Council's floating support worker referred Patsy to the Trust in April 2014, the NHS contract with the Trust, held by the Clinical Commissioning Group, the predecessor organisation to the ICB, required referrals to come from clinicians and they were not able to accept a direct referral from a housing worker.

2.19 Since then, the Trust have widened their referral routes and do now accept direct referrals from housing workers. The Trust also now offer a helpline so that referrers can discuss the most suitable follow up for someone for whom they have concerns.

Surrey County Council Adult Social Care

2.20 In February 2023, a 'deep dive' into the practice, processes and culture in the adult social care team was undertaken to identify any learning and to inform an improvement plan. The deep dive included a desk top audit of 158 contacts received by the social care team during the 4-year period 2017 to 2021 which were closed without apparent management oversight. This audit was undertaken in March and April 2023 by 3 experienced managers.

2.21 To remedy the lack of oversight of closed contacts, a new authorisation process was implemented with effect from 24 April 2023 across all Locality Teams and the specialist teams. All contacts which are not progressing to further work now need to have management oversight and approval prior to being completed.

2.22 A rapid improvement plan within the adult social care team was also initiated, this focussed specifically on the actions taken on duty, the oversight of new referrals and closure of casework. The aim of this plan was to embed robust processes and good practice in the adult social care team and share learning throughout the wider Adult Social Care service via a Community of Practice for Operational Managers. The first Community of Practice event took place on 20 April, over 100 managers attended the event. A key topic for the first meeting was the change in practice around the authorisation of contacts closed without further work.

2.23 A wider audit into the practice and processes of the duty functions across the Adult Social Care teams was also undertaken. The purpose of the audit was to identify any areas of concern, as well as areas of good practice, to build on the work being undertaken in the Woking Locality Team. This work took place in April and May 2023.

2.24 In addition, the interim Director of Adult Social Services led seven mandatory meetings with operational managers in Adult Social Care (170 staff) to focus on the learning from the circumstances relating to Patsy, as well as the learning from our preparation for Care Quality Commission assurance. All operational managers at Assistant Team Manager level and above were required to attend the sessions. These sessions were on average

2 hours long and were supported by the Principal Social Worker, the Head of Safeguarding and the Lead for Practice Improvement and Development.

2.25 Follow up sessions took place in May and June led by the Principal Social Worker and the Head of Safeguarding to focus in more detail on the learning from other sources such as complaints, adult safeguarding enquires, safeguarding adults' reviews, and domestic homicide reviews. These 2 ½ hour sessions also focussed on s11(2)(b) of the Care Act 2014, where a person may refuse an assessment but may be experiencing or at risk of abuse or neglect. These sessions were aimed at manager and assistant team manager roles with the ask that those attending the sessions, cascade the messages and the learning to their teams.

Surrey Heartlands Integrated Care Board [ICB]

2.26 At the time that Woking Borough Council's floating support worker referred Patsy to the Surrey and Borders Partnership NHS Foundation Trust [the Trust] in April 2014, the NHS contract with the Trust, held by the Clinical Commissioning Group, the predecessor organisation to the ICB, required referrals to come from clinicians and they were not able to accept a direct referral from a housing worker.

2.27 Since the time since Patsy deregistered from her GP practice, it has become common place for alerts to be added to the electronic record, to inform the new GP practice of any significant vulnerabilities or risks. This was not in general use in 2014 but represents a significant change in practice in the intervening nine years.

Woking Borough Council

2.28 When Woking Borough Council upgraded their Housing IT system, they have made sure that vulnerability flags do not expire when they are still necessary.

2.29 As part of wider Safeguarding training, Woking Borough Council ran training for all their Housing staff in April 2023 on recognising vulnerabilities and how to add a vulnerability flag to the system. There are guidance notes for the system and the Council is currently updating its procedures on supporting vulnerable tenants. Emerging vulnerabilities will be captured through the new rolling programme or tenant and property visits.

2.30 Since Woking Borough Council brought its housing function back in-house on 1 April 2022, strict measures are now in place for all gas servicing. Where no access is granted for gas servicing, the process now includes home visits, calls and contacting Next of Kin to assess the situation and identify if there is a need to raise an immediate cause for concern. The process also allows them to raise any concerns around vulnerability and living conditions if there are not already identified concerns, and/or to offer support and make the appropriate service referrals. The new process also ensures that Injunctions can be sought quickly and efficiently to gain entry to any homes where gas compliance regulations are not being met.

2.31 The Coroner has reserved for her consideration in the Inquest the matters relating to the validity of the 2018 gas safety certificate and has been supplied with all the background information.

2.32 More extensive use is being made by all parts of the Woking Borough Council Housing Service to log case notes and customer contact on the Council's Housing system. This includes recording contact and non-contact with affected Sheerwater tenants, so that this is visible to the whole Housing team as part of their case management procedures.

2.33 In 2023, Woking Borough Council began a rolling programme of tenancy audits to check who is residing in their properties, as well as on their wellbeing and a basic visual property inspection. This will also be used to identify and flag vulnerabilities. To date, this has focused on geographical areas, starting with Sheerwater and Lakeview. As it is likely to take around three years to complete, Woking Borough Council will supplement this with a risk-based approach to Tenant and Home Visits which prioritises high risk tenants – for example, those without gas in their property (and therefore not requiring an annual gas safety check), those with no repairs requests in a year, and those with irregular rent payments.

3 Conclusions

3.1 Patsy's lifetime of living with Goldenhar Syndrome and her adult experience of mental ill health, created many risks to her wellbeing and to her life itself.

3.2 Mental health and primary care clinicians involved in the early days of Patsy's mental health care, it can be said with hindsight, did not anticipate how the negative symptoms of her delusional disorder would increasingly undermine her ability to live safely.

3.3 As Patsy withdrew from contact with others, the extent of her challenges became less and less visible to people and agencies who might have been able to intervene. When her mental health needs did become visible on occasions, we can see with hindsight that services did not mobilise to respond in ways that secured help for Patsy.

3.4 With the benefit of the knowledge that this review provides, it is now clearer that the clergyman to whom she wrote extensively may have had potential insight into the realities of Patsy's experience. Of course, unless Patsy told him, there was no way he could have known that he was alone in having regular exposure to Patsy's lived reality. Sadly, many years went by before he approached the police in response to his own experience of multiple correspondence, rather than to attempt to secure some support for Patsy.

3.5 However, when he did, and a referral was made by the police to Adult Social Care, this did not result in Patsy being visited, despite some historical records being available to Adult Social Care which revealed important risks. When considered alongside the information in the police referral, this indicated a likelihood of Patsy having immediate care and support needs and a high probability of compromised executive functioning.

3.6 If Patsy had been visited, there would have been an opportunity for the Adult Social Care team, to form a view about her mental state and the precariousness of her existence, offer an assessment and attempt to take appropriate action.

3.7 Patsy's visibility to her landlord as a tenant who had additional needs was either never flagged on her electronic housing records, or the flag was lost when a transfer between two systems took place. Had the flag been there, her landlord could have taken steps to evaluate her ongoing needs and liaise with other agencies as they had done previously.

3.8 Tragically, subject to the findings of the Inquest, it is likely that Patsy was already dead at the start of the Covid pandemic. If she had been identified as a vulnerable tenant, more steps could have been taken to check on her during the lockdown periods and this could have led to the discovery of her body much earlier.

3.9 The gas supply to Patsy's flat was capped in 2019 due to lack of access and no action was taken to address why this had happened.

3.10 Patsy's decision to change GP practices was one that, like any GP patient, she was free to make, but as a consequence the opportunity to act on the housing referral about her mental health needs was lost.

3.11 Finally, the opportunities to involve Patsy's family more directly were lost at the time of her mental health hospital admissions and planned discharges from mental health services.

3.12 The SAR has set out to establish whether there are lessons to be learned from the circumstances of Patsy's care and support, considering the ways in which local professionals and agencies work together to safeguard adults.

3.13 Agencies have done that and have taken steps to address the much of the learning from the events of Patsy's life.

4 Recommendations

4.1 **Recommendation 1:**
Surrey Safeguarding Adults Board: Design and convene a learning webinar to review the circumstances of Patsy's needs and care focusing on therapeutic approaches to people whose mental ill health manifests in negative symptoms, impacting on their executive functioning, potentially leading to self-neglect. Disseminate a recording of the webinar for wider access.

4.2 **Recommendation 2:**
Surrey Safeguarding Adults Board: Design and convene a second learning webinar to review the circumstances of Patsy's needs and care focusing the issues that arise when people who experience delusional disorders also have co-occurring life-long disabilities and childhood trauma. Disseminate a recording of the webinar for wider access.

4.3 **Recommendation 3:**
Surrey Safeguarding Adults Board: Request that the Surrey Chief Housing Officers' Association, convened by the district and borough councils, agenda an item in one of their regular meetings on the findings of this Safeguarding Adults Review. The item should address how communication between next of kin, landlords and the police might be improved when a tenant living alone dies in circumstances that are likely to require the landlord to modify the end of tenancy arrangements. This item should be attended by a representative of the Police and from Surrey County Council Adult Safeguarding Board, with invitations extended to all local Housing Association representatives.

4.4 **Recommendation 4:**
Surrey County Council Adult Social Care: Direct the Approved Mental Health Practitioners Team to carry out a rapid review of the information and support that is made available now to people acting as Nearest Relative within Surrey to ensure that it is appropriate, comprehensive and accessible.

4.5 **Recommendation 5:**
Woking Borough Council: Within the programme of tenant and property visits going forward, review tenants' Next of Kin details to check that they are up to date.

4.6 **Recommendations 6:**
Department of Work and Pensions: Ensure that the findings of this SAR contribute to the national safeguarding policy work that is underway between DHSC and DWP.

4.7 **Recommendation 7:**
Surrey Safeguarding Adults Board Chair: Independently from DWP, ensure that the findings of this review are shared with the members of National Chairs SAB network who are contributing to the national safeguarding policy work that is underway between DHSC and DWP.

4.8 **Recommendation 8:**
All agencies involved in the SAR: Review the learning from this SAR and, where relevant to the agency's remit, ensure that themes are reflected in the agency's training programme and relevant staff briefing.

4.9 **Recommendation 9:**
All agencies who have made practice changes as a result of the learning from this SAR as outlined in section 2 above: Continue to review and audit the outcomes from the practice changes they have made and provide the SSAB with an update report within six months of the publication of the SAR.

4.10 **Recommendation 10:**
Woking Borough Council: Within the programme of tenant and property visits going forward, review tenants' Next of Kin details to check that they are up to date.

The review recognises that implementation of the actions addressed to all agencies will vary from agency to agency and will need to be followed through by action planning on an agency basis.

Appendices

Appendix 1 - Safeguarding Adults Reviews [SARs]

1. Section 44 of the Care Act 2014 places a statutory requirement on the Surrey Safeguarding Adults Board [SSAB] to commission and learn from Safeguarding Adults Reviews [SARs] in specific circumstances and confers on Surrey Safeguarding Adults Board the power to commission a SAR into any other case.

2. Full details of the SSAB's SAR policy can be found at https://www.surreysab.org.uk/wp-content/uploads/2020/03/Safeguarding-Adult-Review-Procedure-v2.0-March-2020.pdf

3. The decision to commission a SAR was preceded by a detailed Adult Social Care safeguarding S 42 safeguarding enquiry in line with the provisions of the Care Act 2014. When this was completed in April 2022, the view at that time was that the circumstances of Patsy's death did not meet the criteria for a mandatory SAR.

4. As a bigger picture emerged of the involvement of other agencies, this view was revised and a request for a SAR was made by Adult Social Care to the SSAB on 1 March 2023.

5. The decision to commission a SAR was made on 30 March 2023.

6. The author for this SAR was commissioned in May 2023.

Appendix 2 - Methodology used in this SAR

1. The purpose of the SAR is to

   - establish whether there are lessons to be learned from the circumstances of Patsy's care and support, considering the ways in which local professionals and agencies work together to safeguard adults;
   - review the effectiveness of procedures (both multi-agency and individual organisations);
   - inform & improve local interagency practice by acting on learning; and
   - make recommendations for future action based on the analysis of reports submitted to the review by the agencies who had contact with Patsy.

2. This SAR focuses on the period 2014 to 2021 but draws on information about Patsy's needs from earlier times in her life.

3. Patsy's family were invited to contribute to the SAR and have shown great courage and determination in addressing the circumstances that led up to Patsy's death, and the events that followed her death. The author met with members of Patsy's family, and they were generous in giving their time to provide key information and answer the author's questions.

4. The following agencies and organisations were invited to contribute to the SAR and how they were involved with Patsy. Each agency was represented on the panel that oversaw the delivery of the SAR.

Department of Work and Pensions	Patsy received DWP benefits at various times in her adult life.
Church of England Diocesan Safeguarding	The agency responsible for safeguarding in the area where the clergyman to whom Patsy wrote currently lives.
Surrey and Borders Partnership NHS Foundation Trust	Patsy was both an in-patient and a community patient of this mental health Trust.
Surrey County Council Adult Social Care	Patsy had some contact with adult social care to support her hearing needs, and they were the agency who were alerted to her vulnerabilities in October 2017.
Surrey Heartlands Integrated Care Board	The ICB is a new organisation, but the two GP practices where Patsy was a patient are within their boundaries.
Surrey Police	Surrey Police responded to Patsy's family member's call to the emergency services in May 2021 and were then involved in responding to finding her deceased in her flat.
Woking Borough Council (in their own right and on behalf of New Vision Homes)	Patsy was a resident of Woking Borough Council and a Council Taxpayer. Between 2012 and 2022, New Vision Homes were the managing agent for Woking Borough Council's housing.

5. Each agency contributed by submitting chronologies, individual management reviews, key historical documents, and by responding to queries. As each agency had different levels of involvement with Patsy each contributed to the SAR in different ways.

6. The panel met five times.

7. The reviewer and author of this report is a retired adult social services and NHS manager with previous experience of reviewing serious untoward mental health incidents, including deaths. She is also someone with lived experience of a visible difference arising from a different condition and is a Trustee of a visible difference charity, Changing Faces. Patsy and her family had no involvement with Changing Faces.

8. The reviewer thanks all the participants in this review, especially Patsy's family who have and will continue to endure deep sorrow about the events that befell their much-loved daughter and sister.

Appendix 3 - Terms of Reference for the Review

SAR Methodology

A “learning together" approach based on analysis of Individual Management Reviews (which will be requested to include critical reflection); an analysis of the combined chronology; and the delivery of one or more practitioner events to be agreed.

Purpose of the Review:

The purpose of a SAR is not to re-investigate or to apportion blame, or to establish how someone died; its purpose is to:

- establish whether there are lessons to be learned from the circumstances of Patsy’s care and support, considering the ways in which local professionals and agencies work together to safeguard adults;
- review the effectiveness of procedures (both multi-agency and individual organisations);
- inform & improve local interagency practice by acting on learning; and
- make recommendations for future action based on the analysis of reports submitted to the review by the agencies who had contact with Patsy.

Scope of the SAR

1. It is the intention for this SAR that it will focus on the period in Patsy’s life when it appears that she became increasingly withdrawn from engagement with others including a range of services.

2. The SAR will first gather background information about Patsy’s contact with health, care and support services during her adult life, focusing on events in her life from 2006, including times when she withdrew from services.

3. The SAR will review any accounts that Patsy’s family and friends are able to give. This will include their own experiences of engaging with health, care and housing agencies; as well as reviewing if any previous trauma and/or adverse life events in Patsy’s life were considered appropriately in engaging with Patsy about her needs, including her lived experience of Goldenhar syndrome and mental distress over the course of her life.

4. The SAR will review the circumstances of Patsy’s meeting and correspondence with a member of the Church of England clergy.

5. The SAR will focus on some detail two key practice episodes:

5.1 A visit by the police to Patsy in October 2017, following a notification to them from the Church of England clergy. The police visit resulted in a referral to Adult Social Care.

5.2 The management by Adult Social Care of that referral in 2017.

6. To understand the context that gave rise to Patsy’s death not becoming known for several years, the SAR will also require information about the regeneration of the estate; her engagement with her landlord; the landlord’s management of gas safety arrangements; her relationship with the Department of Work and Pensions [DWP]; her compliance with bill payments; the landlord and GP’s approach to assessing her vulnerability status during the first year of the Covid pandemic. .

7. The current relevant legislation and guidance that sets out the multi-agency safeguarding responsibilities is the Care Act 2014 and the Care and Support Statutory Guidance 2014.

8. The SAR will also gather information about Patsy's health, care and support needs before the implementation of the Care Act, and potentially across a time period where various national, regional and local safeguarding policies were in place. This will be referenced in the review; however, the intention of the SAR is to focus on the legislative and practice frameworks that were in place in the period following the implementation of the Care Act.

9. The review process will be conducted with the following underpinning principles and guidance in mind:

    - Evidence of Making Safeguarding Personal;
    - Evidence of, or consideration of Mental Health Act & Mental Capacity Act Assessments;
    - Evidence of appropriate family involvement;
    - Evidence of, or consideration of the use of Advocacy;
    - Equalities considerations;
    - NICE Guidelines and pathways;
    - Assessment of risk and management of harm;
    - Information Sharing;
    - Consider any key DWP and Housing policies that need referencing;
    - Consider there are key Church of England policies that need referencing.

10. An assessment of the monitoring and quality assurance mechanisms that each agency had in place, and if these were implemented robustly.

Appendix 4 - The Legislative Context and the Evidence Base for Patsy's services

1. Patsy used a number of state services including:

    - General Practice throughout her life
    - Local Authority Housing
    - Local Authority Adult Social Care briefly in relation to her sensory needs. At the time she used Mental Health services, the services were an integrated health and social care service
    - NHS Mental Health services intermittently during her adult life

2. The circumstances of her death and the commissioning of a SAR means that the SSAB has agreed that at the time of Patsy's death, she had care and support needs as defined in the Care Act 2014[10] and the associated Care and Support Statutory Guidance[11].

3. Agency approaches to safeguarding Patsy should have been informed by the national guidance document Making Safeguarding Personal published in March 2013[12].

4. Each of the organisations that Patsy received services from had duties under the Equality Act 2010[13] requiring attention to be paid to all protected characteristics. For Patsy, this meant that especially her physical and mental health disabilities needed consideration under the terms of this legislation.

5. Patsy drew on a range of DWP benefits over the course of her adult life, each of which were specified in regulations.

6. The legislation and statutory guidance that sets out adult safeguarding roles and responsibilities does not reference the DWP.

7. Two recent SARs, SAR "Billy" [14] and SAR "Valentina"[15], published by Nottingham City's Safeguarding Adults Board, address the need for greater clarity about the interface between the DWP's work and Safeguarding Adults Boards, identifying the need for a shared protocol. A recommendation to this effect was accepted by the then Minister of State for Disabled People, Health and Work in June 2023.

8. The Department of Health and Social Care [DHSC] and DWP are currently working on a joint protocol which will provide guidance on how DWP and Safeguarding Adults Boards work together to support vulnerable claimants at critical moments.

[10] https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[11] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

[12] https://www.adass.org.uk/AdassMedia/stories/making%20safeguarding%20personal.pdf

[13] https://www.legislation.gov.uk/ukpga/2010/15/contents

[14] https://www.nottinghamcity.gov.uk/media/etbdjxmz/billy-final-sar-for-publication-11th-may-2023.pdf

[15] https://www.nottinghamcity.gov.uk/media/xrpcivn3/sar-valentina-final-for-publication-may-2023.pdf

9. Furthermore, the DWP's role in safeguarding vulnerable claimants, including learning lessons from case reviews, has recently been scrutinised through a Parliamentary process.[16] A national report on this work will be published by Parliament in due course.

10. Woking Borough Council had duties to Patsy when she was homeless and then as her long-term landlord when she was known to have additional needs.

11. There is ample guidance on the role that housing agencies have in supporting people to remain safe. The Social Care Institute for Excellence [SCIE] published detailed guidance in 2015[17]. While this guidance was published after some of the earlier interactions with Patsy, it represents a distillation of practice guidance that was already being developed following the implementation of the Care Act in 2014. Housing is an important contributor to people's safety and wellbeing in the community.

12. Gas certification is regulated through the provisions of the Gas Safety (Installation and Use) Regulations 1998[18].

13. Patsy's mental health provision is covered by two different pieces of legislation and their Codes of Practice

    - Mental Capacity Act 2005[19]
    - Mental Capacity Act 2005 Code of Practice (London 2007)[20]
    - Mental Health Act 1983 (amended 2007)[21]
    - Mental Health Act 1983 Code of Practice (various editions)[22]

    While under the care of mental health services, her needs were monitored in line with the Care Programme Approach[23].

14. In 2011 the National Institute for Health and Care Excellence [NICE] published their Clinical Guideline 136 *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services.*[24] There are some important references in this document about the role of family in the support of people using mental health services.

15. In 2014 NICE published their guideline on *Psychosis and schizophrenia in adults: prevention and management*[25]. (It was updated in 2021, outside the time period for this SAR). This document has some references to delusional disorders.

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[16] House of Commons Evidence Session Work and Pensions Committee July 2020
https://www.parliamentlive.tv/Event/Index/2d0d9a4b-4da3-449d-9f03-245c56f8e727
[17] https://www.scie.org.uk/safeguarding/adults/practice/housing
[18] https://www.legislation.gov.uk/uksi/1998/2451/contents/made
[19] https://www.legislation.gov.uk/ukpga/2005/9/contents
[20] https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
[21] https://www.legislation.gov.uk/ukpga/1983/20/contents
[22] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
[23] 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/
[24] https://www.nice.org.uk/Guidance/CG136
[25] https://www.nice.org.uk/guidance/cg178

16. In 2018 NICE published guidance on relating to assessing mental capacity – NICE Guideline NG108 (2018) *Decision-making and mental capacity*.[26]

17. As there are no known associations between Goldenhar Syndrome and psychosis, any co-occurrence is likely to be largely coincidental, and the review author has found no relevant guidelines about the management of both conditions when they affect the same person.

18. The Children Act (2004) was followed up with the government's guidance on Child Protection which is set out in *Working Together to Safeguard Children* first published in 2006. It has been updated regularly since then. This legislation is relevant to Patsy having said that she had experienced some traumatic events as a child.

[26] https://www.nice.org.uk/guidance/ng108