1. Lily

Lily was 34 years old when she was found deceased at her home following a call to Police by concerned neighbours. Her body was in a state of decomposition and her living conditions were described as poor.

Lily was known to several services in the local area as she had complex mental health needs.

There was an inquest into Lily's death. The Coroner recorded that she died of an "unascertained cause, in unknown circumstance".

2. Participating agencies

West Mercia Police, Midlands Partnership University NHS Foundation Trust, Shropshire Council's Mental Health Social Work Team, West Midlands Ambulance Service, Severnside Housing and a local GP Practice contributed to this review.

The full Safeguarding Adult Review can be read here.

3. Non engagement

Services did not find a way of engaging with Lily leading to them closing her to services. Michael Preston Shoot talks about this in his research:

"***Simply sending letters, expecting individuals to respond to clinic/office appointments and closing cases when no response has been received is insufficient***"

8. Communication methods

Lily did not always communicate how she was feeling verbally. Instead, **she preferred to write to professionals**. These letters included disclosures about past abuse, concerns about current harm and her feelings.

If professionals receive letters from individuals, they are working with they should be responded to and considered as a possible indicator of how the person is feeling or what they might want to tell services.

4. Multi-Disciplinary Meetings

There was more than one occasion when there were three or more agencies all struggling to find a way to engage with Lily. **Calling a Multi-disciplinary meeting may have supported them to find a way forward.**

Multi-disciplinary meetings are underutilised. You can read about them in the Responding to Self-neglect Guidance.

7. Opening doors

Practitioners often found it hard to engage with Lily. A Housing Compliance Officer visited Lily's home weekly for eight months, speaking to her through the window or door before Lily started to respond.

This short video on trauma informed practice is useful to show how these practices can "open doors" to those who might be harder to reach.

6. Mental Capacity Assessments

When carrying out assessments of someone's mental capacity, it must be properly recorded. **The decision that the adult is being asked to make should be included in this record.**

The new draft code to the Mental Capacity Act includes changes to the elements of the diagnostic test of capacity. You can read it here.

5. Assumption of Mental Capacity

Practitioners should assume that an individual has the capacity to make their own decisions unless there is a reason to question it.

Lily had an impairment of the brain or mind (which agencies were aware of). This impairment could have affected her ability to make decisions during periods of crisis and **should have led assessments of capacity being carried out.**

Lily's Safeguarding Adult Review

Learning Briefing

March 2023