Northumberland Children and Adults Safeguarding Partnership
County Hall
Morpeth
NE61 2EF
Email: [redacted]

Robert Cohen
HM Assistant Coroner for Cumbria
Fairfield, Station Road,
Cockermouth,
Cumbria
CA13 9PT

Date: 17th April 2025

Dear Mr Cohen,

RESPONSE TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

I write on behalf of Northumberland Children and Adults Safeguarding Partnership (NCASP) in response to your Prevention of Future Deaths Report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

I would like to take this opportunity to express my condolences, both personally and on behalf of NCASP, to Ms Scott's family.

The MATTERS OF CONCERN you raised with the partnership were. –

(1) *Although individual agencies referred me to training they had provided to staff since Ms Scott's death, I also received evidence that, for instance, the GP surgery might not raise a safeguarding referral if the same circumstances were repeated because social services had already been informed. This leads me to be concerned that the message that 'safeguarding is everyone's responsibility' has not been taken on board. I am concerned that future cases will occur in which a multiagency approach is not adopted or that individuals will not make safeguarding referrals because they assume that other agencies are already aware of the issue.*

As a partnership we have given Ms Scott's death, and the learning identified as a result, significant consideration; through the decision to progress to a Safeguarding Adult Review (SAR) and the involvement of several NCASP partners in the inquest. We have previously shared with you the initial findings of the SAR which is a Thematic Review of self-neglect and includes the death of Ms Scott. We would like to take this opportunity to provide a more detailed picture of how practice and multi-agency working has and we expect will change because of this and detail how this will be monitored going forward.

Actions undertaken by NCASP since Ms Scott's death notwithstanding the SAR include:

Updated Self-neglect Policy in 2024[1]
This revised guidance was launched across the partnership during Safeguarding Adults Week in November 2024 and provides guidance for skilled practice in the context of self-neglect. This includes a clutter rating

tool for use by practitioners and outlines suggested responses depending upon the level of risk and harm identified. The policy emphasises the importance of a person-centred approach as well as the need to balance autonomy with protection and a duty of care, which was highlighted in the review of Ms Scott's death. Multi-agency training has been delivered across the partnership to increase awareness of the policy, and training will continue throughout 2025 including with Ms Scott's GP practice in July 2025.

Principles of Engagement across the Partnership[2]
Nine clear and concise principles have been adopted for professionals to consider when working with complex clients including recognition that vulnerability can impact on a person's ability to engage and the potential consequences if we fail to engage the client. These principles were published in November 2024 and are being reiterated within self-neglect training sessions throughout 2025.

Neglect (including Self-neglect) as a Strategic Priority
NCASP have identified neglect as a priority area of work (as from 2023-2026) which we hope will improve outcomes for adults and children. The impact will be measured via assurance work and performance frameworks. A multi-agency task and finish group has been in place since March 2024 and has been looking at the following areas:

- Raising awareness of self-neglect and its impact
- Hoarding
- Substance Misuse
- Informed decision making
- Consider pathways for those that don't meet threshold.
- Engagement
- The impact of and the response to complex chronic neglect
- Learning from neglect summit and SARs
- Training for all partner agencies in relation to neglect.
- Neglect and the impact on the whole family.

Audits of clients at risk of self-neglect have evidenced a range of referral sources including (but not limited to) family, friends and neighbours; community health staff; probation workers; fire service personnel and GPs. Close examination of records includes historic cases as well as recent referrals and consideration of whether appropriate and timely action was taken (including escalation to safeguarding procedures) and if there has been sufficient management oversight. Findings from these audits will be shared with partners across NCASP via the task and finish group work once completed and implications for practice considered and kept under review.

NCASP commissioned [redacted] as an independent reviewer to conduct the SAR as a nationally recognised expert and one of the authors of the second national analysis of SARs, hence he has extensive knowledge of effective practice in learning reviews, in particular self-neglect which currently accounts for 60% of SARs nationally[3].

[redacted]'s initial findings highlighted that *'there was a good understanding of "safeguarding is everyone's business", this being demonstrated by the range of services making adult safeguarding referrals, including Citizens Advice, North East Ambulance Service, care providers, hospital staff and a gas engineer. However…. there had been a lack of escalation of concerns and missed opportunities to refer adult safeguarding concerns.'* This finding echoed your concerns that there may be an assumption that safeguarding referrals are not necessary because someone else is aware of the abuse or neglect.

NCASP have now considered [redacted]'s final report and have committed to accepting and implementing his recommendations in full. Future changes to practice that will be promptly implemented, these include (not exhaustive):

Multi-agency Risk Management (MARM) Framework
NCASP will introduce a multi-agency risk management framework within 6 months, which will set out a shared commitment across agencies who work with risk in Northumberland and will provide practice guidance to practitioners who are working with adults who have multiple and complex needs and are at risk of serious harm or abuse. This framework will support professionals to provide earlier multi-agency intervention than traditional safeguarding procedures and encourage referrals for low level concerns before they become significant and critical.

Policy and Procedure implementation feedback
NCASP will adopt an approach that requires teams across the partnership to feedback when newly introduced policies and guidance, including those on self-neglect have been discussed and the changes to practice that will follow**.** Agencies will be required to report into the Practice Learning Group which meets quarterly, within 3 months of new policies and practice guidance being published.

Impact assessment of learning from reviews
NCASP's SAR Framework and Practice Guidance has been updated to reflect improvements to processes for identifying cases that may warrant review including the introduction of a Rapid Review process which allows earlier identification of areas of learning and good practice. Prior to publication a further requirement will be added that the partnership must review the impact of the learning one-year post completion of a SAR.

In addition, as a Statutory Partner, the Integrated Care Board are taking the lead in relation to ensuring escalation processes and safeguarding responsibilities are widely known and understood across Primary Care services and will ensure evidence of this is shared with NCASP.

I hope this provides you with assurance in response to the concerns you have raised.

Yours Sincerely,

[redacted]

[redacted]**(Partnership Chair)**
On behalf of Northumberland Children and Adults Safeguarding Partnership

[1] north-of-tyne-self-neglect-policy-2024-northumberland-final-version.pdf
[2] ncasp-principles-of-engagement-adults.pdf
[3] Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 (executive summary) | Local Government Association