South Gloucestershire Safeguarding Adults Board

Adult A

Year of Death 2019

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Table of Contents

Preface.....3
1.0 Introduction.....4
2.0 Summary.....4
3.0 Equality and Diversity.....5
4.0 Confidentiality.....5
5.0 Methodology.....5
6.0 Contributors to the Review.....6
7.0 The Review Panel Members.....7
8.0 Author of the Overview Report.....7
9.0 Overview and Background.....7
10.0 Chronology.....10
11.0 Analysis.....10
12.0 Conclusion.....26
13.0 Learning and Recommendation.....27

Appendix A – Summarised Chronology
Appendix B - Recommendations
Glossary
Bibliography

Preface

I would like to begin this report by expressing my sincere sympathies, and that of the review group to the family of Adult A. He will be remembered as a kind person who cared deeply for his family and I am certain that he will be missed by all that knew him. I am deeply sorry for his family's loss and I hope that in some way this report provides an insight to part of his life and a voice to his story.

I would like to thank the review group and those agencies that provided chronologies and review reports for their time and cooperation.

1.0 Introduction

1.1 This report relates to a Safeguarding Adults Review (SAR) which was commissioned by South Gloucestershire Safeguarding Adults Board and examines the interaction by local agencies in relation to Adult A, prior to the point of his death on the 19th January 2018.

1.2 On Friday 20th September 2019 an extraordinary meeting of the SAR subgroup took place following a referral from the Quality Assurance Sub Group chair regarding the death of Adult A.

1.3 Adult A was one of the subjects of the Local Safeguarding Adults Board (LSAB) quarterly multi-agency audits on a theme of self-neglect. The QA sub group reviewed some anonymised records from agencies who had been working with Adult A and there was concern that agencies had not worked as well as they could with Adult A and with each other.

1.4 The chair of the QA sub group made a SAR referral about Adult A following concerns raised during the audit about multi-agency working prior to his death. A 'rapid review' approach was taken to gather information from organisations that had been in contact with Adult A prior to, and immediately after, his death.

1.5 A recommendation was subsequently made to the South Gloucestershire Safeguarding Adults Board (SGSAB) chair to undertake a Safeguarding Adults Review as there was evidence that this referral met the criteria for undertaking a SAR according to the Care Act. This was agreed and the process for the SAR commenced in November 2019.

1.6 This report will consider the contact and involvement that agencies had with Adult A between the dates of 1st January 2018 and the 31st January 2019 and whether there were opportunities to provide him with additional support or to accessing services. The reason for choosing these dates is that they provide a comprehensive overview of the deterioration of Adult A's mental and physical state that led to his death.

1.7 By taking a holistic approach the review has sought to identify appropriate learning and to make recommendations to assist in reducing the chances of such deaths occurring in the future. Every effort has been made to conduct this review process with an open mindset and to avoid hindsight bias. Those leading the review have made every attempt to manage the process with compassion and sensitivity.

2.0 Summary

2.1 Adult A was a single male who was thirty one years old and was living alone in a town in South Gloucestershire. Adult A's parents had separated and he had previously lived with his father prior to him moving out. Adult A had been living at his flat since 17th July 2006 and was being supported by his mother and brother.

2.2 According to his family Adult A had started drinking alcohol from the age of about twelve and agency records show that he had become alcohol dependant from the age of sixteen. He was a regular user of health services. Adult A had been supported by agencies over a number of years but due to his addiction, his mental health and physical state had rapidly declined in recent years.

2.3 Adult A was deemed by those professionals that worked with him to have capacity (although he was never formally assessed) and able to make his own decisions. Due to the complexity of his condition Adult A would however find it difficult to fully engage with services and attend the appointments that were made for him.

2.4 Adult A would often attempt to self-detox, despite being advised not to do so by health professionals. These attempts led to his potassium levels becoming dangerously low to an extent that he had becoming increasingly reliant on health professionals for emergency treatment.

2.5 On the 9th January 2019 Adult A was found deceased at his home address by his mother and brother. At the time of his death Adult A was aged thirty one.

2.6 A post mortem identified that the cause of death was related to alcohol dependency and Hyponatremia (low sodium levels).

3.0 Equality and Diversity

3.1 The review adheres to the Equality Act 2010 and all nine protected characteristics (age, disability, gender re-assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation) were considered by the Review group as part of the terms of reference and throughout the review process.

3.2 As far as the Review Group has been able to determine, Adult A did not hold any strong or religious beliefs or have any language or acute learning needs which would have impacted on any services that were offered to him.

3.3 There is no evidence that would indicate that Adult A was discriminated against by services or individuals with whom he came into contact with and no barriers to accessing services in relation to inequality were identified.

4.0 Confidentiality

4.1 The findings of this review are confidential. The Information obtained as part of the review process has only been made available to participating professionals, and their line managers.

4.2 The content of the overview report has been anonymised to protect the identity of Adult A, relevant family members and all others involved in this review.

5.0 Methodology

5.1 This review adheres to the provisions specified within the Care Act 2014 and has used a systems based methodology. This approach was facilitated by an independent Chair who was supported by a review group from the relevant agencies.

5.2 South Gloucestershire Safeguarding Adults Board identified the following issues as key aspects that were required to be explored by this review:

- Establish whether any training or awareness raising is required and establish any lessons to be learned about the way in which local professionals and organisations

work individually and together to safeguard adults at risk. Apply lessons to service responses and changes to policies and procedures as appropriate.
- The final product must be something from which key issues and recommendations can be easily understood.
- Learning should be clear and timely to allow for quick dissemination and changes in practice.

5.3 Following the decision to undertake the SAR South Gloucestershire Safeguarding Adults Board arranged for all relevant agencies to check their records about any interaction that they had with Adult A. Where it was established that there had been contact the Partnership ensured that all agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become review group members.

5.4 Frontline professionals and their supervisors were also asked to provide information, relevant documentation and identify the learning from this tragic case. Eleven reports and chronologies were completed by all relevant agencies that had become involved in the care and support of Adult A.

5.5 Due to the advent of the Covid 19 pandemic panel meetings and practitioner events had to be cancelled and where appropriate professionals were individually contacted for additional information. This information included, recent SARs, policy and procedures and independent medical advice from suitably qualified professionals.

5.6 The independent report author spoke to Adult A's mother and brother. Their views in relation to the multi and single agency response to Adult A's needs have been reflected in this report. A copy of the report has been given to the family.

5.7 In view of the fact that Adult A was not working during the time covered by the terms of reference no work colleagues were seen as part of this review. Due to him being largely socially isolated no friends or neighbours were identified that could assist the review.

6.0 Contributors to the Review

6.1 The contributors to the SAR were;

- South Gloucestershire Adult Social Care
- Primary Care – General Practitioner (GP), BRISDOC out of hours service
- Avon and Wiltshire Mental Health Partnership (AWP)
- North Bristol Trust (NBT)
- Avon and Somerset Police
- South West Ambulance Service Trust (SWAST)
- United Hospitals Bristol (UHB)
- Avon Fire & Rescue (AFRS)
- Developing Health & Independence (DHI)
- Bromford Housing
- Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG)

7.0 The Review Group Members

7.1 The review group for this review were made up of the following representatives;

- Paul Northcott - Independent Chair
- Nikki Rice (Vulnerable Adults Manager) - AFRS
- DS Hayley Simmonds – Avon and Somerset Constabulary
- Debbie Bilton (Named Professional Safeguarding) -SWAST
- Alison Findlay (Health and Wellbeing Service Manager) Southern Brooks Community Partnership
- Rhiannon Holder (Integrated Service Manager) DHI
- Amanda Robbins (Locality Manager) Bromford Housing
- John White (Mental Health Services and DoLS [1] Team Manager South Gloucestershire Council
- Sarah Pearce (Patient Safety Manager) BrisDoc
- Hannah Scaife (Principal Social Worker) South Gloucestershire Council Adult Care.
- Kirsten Bowes(Safeguarding Manager) BNSSG CCG
- Rosie Closs, Public Health Programme Lead, Drugs and Alcohol Programme (DAP)

7.2 None of the panel members knew Adult A, had direct involvement in the case, or had line management responsibility for any of those involved in his case.

8.0 Author of the Overview Report.

8.1 South Gloucestershire Safeguarding Adults Board appointed Paul Northcott as Independent Chair and author of the overview report on the 29th November 2019.

8.2 Paul is a safeguarding consultant specialising in undertaking safeguarding and critical incidents reviews and currently delivers training in all aspects of safeguarding. Paul was a serving police officer in the Devon and Cornwall Police and had thirty-one years' experience. During that time he was the head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to adult care.

9.0 Overview and Background Information (The Facts)

9.1 Adult A has been described as a kind person who cared deeply for his family. Adult A described himself as a 'loner' and was generally socially isolated. He was living alone in one bedroomed flat owned by a Housing Association and he had little contact with the outside world. Adult A didn't know his neighbours (records held by GP) and he had no partner or friends. Adult A had on one occasion stated that he did not see another 'single human being' unless it was interaction with professionals (DHI records).

9.2 Adult A's family state that he had previously been employed as a forklift driver and as a postman who had delivered mail internally within an organisation. Adult A had to give up his work due to him having what was described by his family as seizures. He had not worked for a number of years prior to his death.

9.3 Adult A had stated to professionals that he did not want to be 'bored and die young' (which is where he felt that he was heading) and that he 'wanted to work, have hobbies and

[1] Deprivation of Liberty Safeguards

friends'. He stated that his aspiration was 'to live past 40'. Agency records show that Adult A had the desire to change his behaviour but the complexities of his condition and addiction prevented him from having the self-discipline or motivation to do so.

9.4 Adult A reported to an approved mental health professional (AMHP) that he had a difficult relationship with his parents in his teenage years and he had left home at the age of sixteen. Since that time he had lived alone and his contact with the outside world had steadily diminished. Adult A's father took his own life in June 2015 and he had stated that this had been a pivotal point in his life when he had spiralled further into alcohol abuse. Despite these difficulties Adult A was supported on a regular basis by his mother and brother who would buy his shopping and tidy up his flat.

9.5 Adult A was extremely vulnerable in terms of his alcohol dependency, attempts at self-withdrawal, poor mental health and self-neglect. In October 2018 whilst engaging with alcohol services he was suffering from 'refeeding syndrome' (blood level imbalances owning to drinking excessively, missing food and then drinking less and eating more which can lead to serious illness or sudden death). GP records (11/01/18) show that he was depressed and ashamed of his life. Adult A was also suffering from anxiety and had reoccurring concerns about financial support and eviction. His housing association worked with his support worker to actively manage his case.

9.6 Adult A had regular contact with his GP and was taking prescription medication (Thiamine, Ranitidine, Colecalciferol, MagnaPhate and Sanatogen A-Z). Hospital records show that it was unclear whether he was regularly taking his medication despite it being prescribed in a dossett box[2].

9.7 Adult A was being supported by professionals in the community. The agencies working with him included DHI, Southern Brooks, Bromford Housing, GP and Adult Social Care, all of whom had regular contact with Adult A. All of the professionals working for these agencies were aware of the risks associated with his health problems and his decline into self-neglect. Many professionals carried out home visits and they not only supported him from a health perspective but they also assisted him with everyday life such as benefit claims, organising appointments and providing tenancy advice.

9.8 Personal support was provided by Southern Brooks and DHI and Adult A was allocated a support and wellbeing worker. Adult A's community support package included one to one engagement, peer group support and counselling. Adult A also engaged with West of England Works project which provided assistance in relation to finding employment or accessing education and training. During the period covered by the review Adult A was constantly signposted to numerous other agencies to assist him with his addiction, his grief in terms of the loss of his father and daily life.

9.9 Adult A was however difficult to manage and he would often refuse to engage with professionals and/or attend appointments. This behaviour was clearly driven by the complexities of his addiction and its influence on his behaviour. As a result Adult A's treatment and community support programmes would be compromised and he continually needed emergency medical treatment.

9.10 Adult A needed close supervision to ensure that he attended arranged appointments. He would often state that this was down to feeling too ill but on many occasions it was down to the fact that he was too intoxicated to attend. As a result it was hard to provide him with comprehensive and consistent support. In order to overcome this and due to the

[2] Organiser used to help individuals keep track of their medications and to remind them of when/how often they should take them.

fact that he didn't like to use public transport professionals attempted to accompany him or remind him of the importance of attendance.

9.11 Adult A also appeared to be prepared to take risks in terms of his withdrawal from alcohol and the route that he chose to take was in contradiction to the advice that he was given by Health professionals. There is little doubt that this behaviour was driven by the effects of alcohol but his attempts at unsupervised detox would lead to him constantly vomiting, failing to adequately eat or drink fluids, anxiety attacks, pain in his abdomen, legs and feet and a loss of mobility (crawling around his flat). He also suffered from rapid weight loss as he had no appetite and would resort to just drinking milk and water in order to maintain hydration.

9.12 From the information available it would appear that Adult A would drink spirits to excess and these included vodka and whiskey. The volume consumed by Adult A would appear to have varied considerably and was difficult to assess from the records held by agencies (SWAST records state that it was up to a litre a day).

9.13 Adult A was a frequent user of Health services. This contact included appointments with primary services who had attempted to manage his addiction through a coordinated approach with other agencies (DHI, Southern Brooks). There were eight presentations (within the timeframe of this review) at the local Accident and Emergency Department and Out of Hours services (four occasions during the review period), for alcohol dependency and failed self-withdrawal attempts. There were numerous incomplete treatment episodes recorded during the period of the review, including inpatient assessments, due to him discharging himself from hospital.

9.14 Adult A had registered with his GP in 2007 and he was diagnosed with alcohol dependency in June 2011 although his GP states that following a consultation it was established that there were many years of heavy consumption prior to this. Records identify that there were varying levels of engagement with the surgery and often he would not readily engage with the services that were offered to him. Adult A's GP has stated that in their opinion he had capacity and no underlying mental health conditions.

9.15 Concerns had been raised about Adult A's mental health (DHI, Southern Brooks) as he presented on occasions with psychosis. There was however no formal diagnosis of a specific mental illness by any of the health professionals that saw him including his own GP. Despite his health declining Adult A was never deemed to be in such a mental state that he needed to be securely accommodated under the Mental Health Act 1983[3].

9.16 On those occasions where Adult A called for an emergency treatment the response was appropriate and timely (SWAST responded to Adult A on nine occasions in the four months prior to his death).

9.17 Following a referral from his GP (17th October 2018) Adult A's case was being managed by Adult Social Care. His allocated social worker constantly made attempts to contact Adult A but had failed to establish any meaningful interaction as he had failed to return their calls. This will be discussed further in section 11.

9.18 In the months leading up to his death Adult A's mental and physical state continued to deteriorate and caused concerns for all of those that were involved in his care.

[3] The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.

9.19 Adult A's mother had last seen her son three or four days before his death. His family had stated there had been a marked deterioration in his health in the weeks leading up to his death to an extent where he had almost become immobile. His mother stated that she tried to contact Adult A the day prior to his death but there was no reply.

9.20 Adult A's death was discovered by his mother and brother who had entered his flat after seeing that there was uncollected food outside of his front door.

10.0 Chronology

10.1 A condensed chronology can be found at Appendix A. This chronology covers the time period as per the terms of reference and details Adult A's interaction with agencies.

11.0 Analysis

11.1 This part of the overview will examine how and why events occurred, information that was shared, and the decisions/actions that were made. It will consider whether different decisions or actions may have led to a different course of events. The analysis section seeks to address the terms of reference and the key lines of enquiry within them. Examples of good practice are also highlighted in the sections below.

11.2 Alcohol Dependency

11.2.1 Agency records show that Adult A had developed alcohol dependency from a very young age although it is not clear what the initial trigger was for him to develop this addiction. Adult A's GP believed that his alcohol dependency was attributable to his mental health issues and his inability to cope with 'his thoughts'.

11.2.2 Adult A understood that this alcohol dependency was harming his health and had previously stated that ''[vodka] is destroying me'. Adult A was also aware that if he continued to drink alcohol to excess and to self-detox without a structured treatment programme this could lead to death. Despite this awareness Adult A stated that he would 'always be a drinker' and saw 'nothing wrong with 'the occasional drink'. This decision, which was driven by his addiction, made his condition difficult to manage and limited the treatment options that were available to him and Health professionals.

11.2.3 There is clear evidence nationally[4] of the detrimental impact that alcohol can have on the lives of individuals and how the addiction to these substances also increases the risk of harm and abuse. These risks were clearly evident in this case.

11.2.4 Throughout his journey with alcohol dependency Adult A engaged with health staff on a regular basis (see section 11.7 regarding treatment and support) and they had full knowledge of the affect that it was having on his health. There are many entries within his health records regarding the attempts to effectively manage his substance addiction. There was also evidence of staff discussing with and encouraging Adult A to develop self-coping strategies with their support and guidance (through diaries, peer support groups) in an attempt to motivate him to make the necessary changes that were required for him to lead a healthy life. This should be seen as good practice.

11.2.5 There were periods when Adult A appeared to want to take back control of his life (22/01/18, 03/07/18), however these moments were often short lived (on the 22/05/18

[4] Hjemsæter et al (2019).

he reported that he hadn't been drinking for five days). On those occasions where he had attempted to take control he was unable to effectively manage his withdrawal and this led to periods where he was forced to seek medical assistance. During these periods records show that Health agencies provided the care and treatment to the standards that would be expected.

11.2.6 The risks associated with Adult A carrying out home detox were well known (letter sent by the alcohol unit at the hospital to his GP) and evidence recorded in agency records show that all of those professionals that worked with him were actively trying to dissuade him from attempting this self-imposed regime. Adult A was also continually advised that any detox programme needed to be supervised and the risks of failing to do so, including the possibility of him dying, were constantly reiterated to him (as evidenced in Health and DHI records).

11.2.7 Within South Gloucestershire whilst DHI currently have no waiting list there is an acceptance by professionals working within Health and Social Care that recognised pathways are limited in terms of the services offered and the ability to deliver long term support. These limitations to service delivery are not unique to South Gloucestershire and are prevalent on a national basis[5]. As a consequence professionals have no choice but to prioritise those that are willing to address their addictions over those who are unable to motivate themselves to do so. In Adult A's case where his reluctance to give up alcohol and failure to attend appointments forced professionals to make decisions about his care and prevented him from accessing treatment pathways. There has been nothing found by the review that would indicate that the rationale for such decisions was inappropriate in this case. Such decisions were clearly documented and discussed with Adult A, supervisors and managers.

11.2.8 On reviewing the circumstances of this case it has been identified that there is currently no hospital detox pathway for individuals who are too unwell to detox in the community, or within inpatient facilities. In terms of improving practice the DHI review report author commented that a detox pathway should be created that would enable professionals working in the community to directly refer cases to hospital. Such a pathway would reduce the number of emergency admissions and would assist with the early treatment of individuals **(Learning point 1- Recommendation 1)**.

11.2.9 The DHI review report author also identified that whilst there are treatment services available to clients like Adult A additional capacity is still required to meet current and future needs. Ideally the service provided by the Alcohol Team at Southmead Hospital should be increased to provide extended out of hours cover over seven days a week. This level of service would increase the likelihood of clients, like Adult A, being seen by specialists who could provide intervention and advice. This service is necessary especially for those clients who have a history of self-discharging prior to being examined or being treated **(Learning point 2 - Recommendation 2).**

11.2.10 In Adult A's case where professionals predicted that he could die as a result of his behaviour it has been identified that he and others like him should have had an end of life pathway. Such a pathway should provide a clear plan in respect of palliative care alongside alcohol support options **(Learning point 3 - Recommendation 3**).

11.2.11 In Adult A's case his alcohol dependency had a clear impact on his health and on his ability to cope with everyday life. This in turn led to him self-neglecting which will be discussed further in the next sections of this report.

[5] Centre for Social Justice (2007)

11.3 Adult A's Mental Health

11.3.1 Adult A's alcohol addiction had a severe impact on his mental health and ability to cope with life. The death of Adult A's father (June 2015) was seen not only as the catalyst for his increasing dependency on alcohol but also as one of the major factors in the decline of his mental health.

11.3.2 From their interaction with Adult A some professionals (Health, DHI) felt that he did have executive dysfunction[6]. His symptoms included the inability for him to retain and utilise information that was given to him particularly about self-detoxication.

11.3.3 When intoxicated Adult A would be incoherent, have a poor recollection of events and his capacity to make decisions was severely impaired. Whilst there was no diagnosis of mental illness in his case there was evidence in agency reports which indicated that there were occasions when he did have psychotic symptoms. These symptoms included difficulties in concentration, anxiety, depression, confusion and hallucinations (Brisdoc 25/09/18). On the 18/01/18 in a telephone call to Southern Brooks he was described as 'chuntering', speaking strange words and at that time there was an assumption that he was having a seizure. On this particular occasion he eventually started talking again but was not able to remember who he was talking to and stated that he had mislaid his phone despite him using it.

11.3.4 On those occasions where he did exhibit periods of irrational thinking, efforts were made to provide appropriate support him and to refer him to other agencies and these interventions are evident in records.

11.3.5 On each occasion when Adult A did present to agencies with mental health concerns he was appropriately assessed. These assessments were informed by historical and multi-agency information but their completion was often frustrated by Adult A's unwillingness to engage or the fact that he was too intoxicated to complete them. Based on the assessments that were made in this case professionals did not find any evidence of any underlying acute mental health disorder. Professionals concluded that Adult A's symptoms were indicative of alcohol dependency or withdrawal symptoms and he therefore did not reach the thresholds laid down by the Mental Health Act for more structured intervention. There has been nothing identified through the review process that would contradict this view.

11.3.6 Adult A was therefore provided with mental health support in the community including Talking Therapies[7]. It was during this process the impact of the death of his father was identified and he had been appropriately signposted to other support agencies such as Cruse[8] for bereavement counselling. It is not clear however from agency records whether Adult A actually utilised these support networks or whether this aspect of his life was fully explored further with him. This was an opportunity that was missed by those working with him to fully understand the motivations behind his behaviour.

11.3.7 Professionals working within South Gloucestershire recognise that individuals like Adult A are often stuck in a cycle where they cannot reduce their addiction without

[6] Executive dysfunction is a term used to describe the range of cognitive, behavioural, and emotional difficulties which often occur as a result of another disorder. Individuals with executive dysfunction struggle with planning, problem-solving, organisation, and time management all of which were shown by Adult A.

[7] Counselling and psychological therapies.

[8] CRUSE offers free and confidential one-to-one support for bereaved people.

specialist mental health input, however, they are unable to access such services due to their dependency on the substance. In order to improve current service provision to individuals like Adult A the panel felt that the pathway between treatment services and mental health services should be reviewed and strengthened to ensure there is a dual diagnosis strategy to support clients **(Learning point 4 - Recommendation 4**). Any development of a strategy must include recognition of the impact that such clients have on the voluntary sector.

11.3.8 Additional improvements to the services that could be provided were also identified by Adult Social Care. Those involved in the review identified there was no evidence in records that a strength based approach (also used by DHI and Southern Brooks staff) had been adopted or that Adult A had been asked about the positive things in his life in an attempt to improve his mental wellbeing. Such an approach could have assisted him in improving his feelings of self-worth and his motivation to work with agencies to improve his life chances (**Learning point 5**).

11.3.9 Police representatives also identified that there are current operational weaknesses in terms of the availability of mental health referral pathways. Such pathways have been identified as critical in the management of complex cases by emergency response staff. Progress towards improving these pathways is currently being overseen by the Avon, Somerset and Wiltshire Mental Health Crisis Concordat strategic meeting and therefore the panel felt that there was no requirement to include a specific recommendation in relation to this matter.

11.3.10 In summary mental health engagement with Adult A followed occasions when he actively sought help for his mental wellbeing or opportunistically, with consent, when presenting to community and primary services or at hospital. On these occasions he was signposted to appropriate agencies and reminded of the additional support that he could get from his GP and other local services. Whilst current pathways and dual diagnosis strategies could be improved the level of support received by Adult A was comparable to that provided to any other individual who would have prevented with similar symptoms and who had not been deemed suitable for more structured treatment programmes.

11.4 Capacity

11.4.1 The next area for analysis is whether Adult A had capacity to make informed decisions in his life and able to effectively look after and protect himself from harm.

11.4.2 In similar vein to the issues identified in respect of mental health records show that professionals held mixed views about Adult A's capacity. In this case some agencies (SWAST/DHI) did question whether Adult A had capacity[9] and concerns had been raised in relation to his short term memory and the possibility of an alcohol related brain injury which could have impaired capacity (Hospital Alcohol Team records 17/10/18). The fact remained however that when Adult A was sober he was seen by those professionals that were supporting him as being capable of making informed decisions.

11.4.3 On occasions there was clear evidence in agency records that Adult A displayed full capacity (GP) and there were moments in his life when he had attempted to take control and was able to clearly articulate what he wanted in terms of engagement and treatment. Adult A was deemed to have capacity on the 23rd November 2018 when he was assessed by a paramedic to make decisions regarding healthcare plans.

[9] An entry in the DHI records (09/01/19) questioned whether he had capacity to decline social care involvement and yet this was never pursued.

11.4.4 The Mental Capacity Act 2005 (MCA) clearly states that professionals should always assume that clients have capacity unless they are able to establish otherwise. The Act sets out a two stage test that must be used to demonstrate incapacity. The first part of the test would be to establish whether Adult A had an "impairment or disturbance in the functioning of mind or brain". The second part of the test relates to whether such an impairment or disturbance prevented Adult A from being able to understand, retain, use, weigh up and communicate his decisions.

11.4.5 The clarity of Adult A's decision making and his ability to effectively care for himself was undoubtedly influenced by his anxiety, depression and alcohol dependency. In his particular case his capacity would regularly fluctuate. Issues regarding fluctuating capacity, mental health and alcohol dependency and its impact on conducting accurate mental health assessments has been the subject of national research[10]. Such research has shown that there is often differing opinions in relation to the nature of addiction and its impact on capacity which means that professionals have to rely on their own professional judgement when considering when and how the MCA should be applied. This makes cases like this one complex in terms of the decisions that professionals have to make.

11.4.6 Nationally substance dependant adults are often viewed as making unwise 'lifestyle choices'[11]and where possible professionals are advised that they should wait for the person to be able to make decisions. As a consequence staff within agencies often feel disempowered when dealing with such individuals like Adult A and assume that there is little that they can do to intervene particularly where the adult is not ready to address their addiction.

11.4.7 Adult A's complex condition drove him to isolate himself from agencies and the outside world. On occasions he would turn his phone off (Southern Brooks 12/01/18) and refuse assistance. There were several occasions where agencies (DHI, AFRS, SWAST) had tried to convince Adult A to allow them to refer him to Adult Social Care but he had refused. On other occasions Adult A had agreed to a referral being made but when Adult Care contacted him he had then refused their support. There was also evidence that Adult A's support worker had contacted social care without his knowledge but was informed that they had to have his consent in order to proceed. All of these factors made meaningful engagement extremely difficult for those agencies that were looking to support him.

11.4.8 Capacity is a complex issue particularly for those like Adult A who are involved in substance misuse and often, in order to comply with legal requirements, those trying to manage their cases have to wait until the individual has regained capacity before decisions can be made. This presents a challenge for agencies to deliver effective intervention as on occasions they are unable to wait for the person to regain capacity. In Adult A's case he would often leave Health premises or fail to engage which compounded these issues.

11.4.9 Where professionals believe that an individual is unable to effectively make decisions then intervention to safeguard the wellbeing of that person may be legitimate in their 'best interests'[12]. Adult A's family felt that he had reached a point in his life where significant harm was inevitable and that agencies needed to be proactive in pursuing

[10] Cragie (2019); Keane (2020)
[11] Third principle of the MCA.
[12] Best interests principle. ... If a person has been assessed as lacking capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.

all avenues of support for him. From the records held it would appear that no one had formally considered whether 'best interest' intervention was required in this case, particularly in view of the risks that were identified and the level of self-neglect that was taking place. If it was considered and not felt to be relevant (as Adult A had capacity) then the details were not recorded.

11.4.10 The fact that professionals were taking Adult A's refusal of support at face value and that professionals felt that no action could have been taken without his approval was never challenged and it was identified by Adult Social Care that frontline staff appear to have worked to an over simplified model of mental capacity and consent. This has been a reoccurring issue nationally in other similar cases[13].

11.4.11 Adult Social Care have identified that the decisions that were made in June 2016 which had concluded that safeguarding or other referrals could not be progressed because Adult A had not explicitly consented was not compliant with the Care Act 2014 or local policy[14]. There will undoubtedly be occasions where making referrals without a person's consent would be justified particularly if it is felt that they are in imminent danger from abuse or neglect as some believed to be the case for Adult A. Similar issues were highlighted in an internal guidance[15] in 2018 which had led to changes in internal and external guidance and the Association of Directors for Adult Social Services (ADASS) framework used for making S42[16] decisions. Whilst outside the time period for the review this has been included as it demonstrates that practice is not fully embedded across the South Gloucestershire partnership. Had this practice been in place then this could have meant that Adult Social Care support was provided at an earlier point in Adult A's life (**Learning point 6**). It should however be highlighted that even had this occurred on the evidence that is available it is unlikely that this would have changed the outcome in this case due to his refusal to engage with services.

11.4.12 During the review it was identified that many key workers do not receive any training in relation to capacity and the issue of consent. The panel felt that due to staff turnover and the need for continuous professional development that additional training was required. AFRS service, Adult Social Care and Mental Health Services have all identified that where consent is not provided many professionals will fail to look at or be aware of alternative courses of action. The panel felt that this could equally be applied to all agencies involved in the review. This needs to be addressed through training and awareness campaigns **(Learning point 7 - Recommendation 7**).

11.5 Self-Neglect

11.5.1 Adult A met the definition of vulnerability used by statutory agencies[17] and Adult Social Care had considered this as part of their assessment process. Adult A had suffered for years with low mood and anxiety and he often felt unwell experiencing a range of symptoms due to his alcohol dependency and attempts at withdrawal. Adult A also had a poor diet and sleep pattern. Each of these factors made him vulnerable to self-neglect and in constant need of the support which he would often turn away.

11.5.2 Research has identified that health and social care professionals often find self-neglect cases like Adult A to be enormously challenging and fraught with ethical and legal

[13] Preston-Shoot M (2019)
[14] South Gloucestershire Safeguarding Adults Policy (2017)
[15] South Gloucestershire Self Neglect Guidance (2019)
[16] The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.
[17] Adult at Risk - An Adult at risk of abuse or neglect is defined as someone who has needs for care and support, who is experiencing, or at risk of, abuse or neglect and as a result of their care needs - is unable to protect themselves; Care Act (2014).

dilemmas, particularly when adults are judged to have mental capacity but refuse support[18]. Feedback from staff involved in the review however would indicate that there is confidence in South Gloucestershire in dealing with such issues. The South Gloucestershire multi-agency self-neglect guidance[19] is clear in its expectations for all agencies and on review was found to be robust in its content.

11.5.3 All of those agencies involved in the review have demonstrated an ongoing commitment to improving awareness and service delivery to people who self-neglect. Southern Brooks have introduced risk protocols that support staff in identifying and mitigating risks and AFRS, the Police and Bromford Housing have developed internal safeguarding structures and guidance to provide advice and guidance to all frontline staff. This should be seen as good practice and further development encouraged.

11.5.4 Improvements in practice in this area will be discussed in section 11.8.

11.6 Risk Management – Adult A

11.6.1 There were significant risks identified in Adult A's life and these included;

- Alcohol dependency
- Anxiety/depression
- Self-neglect
- Self-isolation
- Mental Health
- Deteriorating health (organ failure)
- Vulnerability to withdrawal seizures (which could be dangerous as he lived on his own)
- Death (raised by Housing -Multi agency meeting August 2018/ GP)
- Fire
- Eviction

11.6.2 The review has identified that the risk management of Adult A was actively considered by Health services in relation to mental health and substance abuse. There was also evidence that his GP had put into place measures such as monitoring non-attendance at appointments or when he failed to collect his dossett box in order to mitigate risks associated with his ability to manage his own health and welfare.

11.6.3 Other agencies such as Police[20], Housing and DHI also demonstrated that they had risk management processes in place to deal with those events where they came into contact with Adult A.

11.6.4 Whilst each agency was looking at risks factors that were pertinent to their own organisation there was also a collective understanding of the issues that Adult A was facing due to the multi-agency information sharing that took place. Each agency documented risk factors and plans initiated to mitigate those issues that they had identified. Adult Social Care have however identified that it would have been helpful to have had a specific and recorded discussion about risk factors and protective factors with all of the key professionals involved in this case as this may have identified patterns and ensured that there was a holistic approach to working with Adult A.

[18] Braye (2015)
[19] South Gloucestershire multi-agency self-neglect guidance (2019)
[20] ASC have introduced **BRAG** (Blue, Red, Amber and Green ratings) a vulnerability assessment tool , which allows for a comprehensive assessment of vulnerability and risk, which then feeds into safeguarding action plans.

11.6.5 In addition to the aforementioned risks, concerns had also been raised in relation to the possibility of Adult A taking his own life (previous attempt in 2013). On one occasion Adult A was described by a professional working in Southmead hospital as presenting with a low mood and that he 'has high suicide indicators', and that he had 'access to lethal means'. On another occasion Health professionals were uncertain as to whether Adult A had drunk four bottles of vodka in an attempt to take his own life and despite this he was not referred to any mental health support. Adult A had also stated to DHI professionals that he would often think 'about the way that he [his father] did it'. These risks are recognised as increasing the probability of a person taking their own life[21] and yet don't seem to have been fully appreciated, or if they were they were not documented, by professionals who were working with him. Where such risks are clear then they should be clearly documented and mitigated. This finding has not resulted in a specific recommendation as all agencies have the policy and processes in place to do this but they were not adhered to in this case.

11.6.6 There were also occasions where a specific increase in risk was not clearly identified and acted upon such as when he declined further contact and support and yet he was known to be in a low place in terms of his mental health. On the 26th May 2018 Adult A sent a text to his key worker stating that 'I think that I am done, Thank you'. On the 17th December 2018 Adult A told his social worker that his brother was taking him to visit his dad's headstone and that the time of year (just before Christmas) was difficult for him. Unfortunately notes don't indicate whether this was explored with him or the possible increase in risk acknowledged and mitigated.

11.6.7 On the 20th December 2018, Adult A's social worker spoke to him for the last time and he asked her not to contact him until after Christmas to arrange a visit. On the 31st December 2018, a message was left by the DHI Drug and Alcohol Worker asking Adult A's social worker to contact them. That contact finally took place on the 9th January 2019 when the DHI professional stated that Adult A had told them that he didn't want to see them or the social worker again. This delay was unacceptable and in the interim period his risk assessment should have been reviewed.

11.6.8 The DHI review writer has identified that had Adult A's case been discussed with DHI management then there may have been an opportunity to escalate and share information, including risks. The review writer has however highlighted that it was not clear, at the time, whether frontline staff knew how to escalate such a case (i.e. via the Safeguarding process or via a supervisor). This issue has been addressed through additional training within that organisation. The panel has however identified that the escalation process[22] is not fully embedded into practice in South Gloucestershire and that staff from all agencies should be reminded about the existence of the document. Individual agencies should also ensure that training in this area is revisited on a regular basis and that the process is explained to new staff (in appropriate roles) during induction (**Learning point 8**).

11.6.9 Once allocated to a social worker in Adult Care then a formal assessment (which would have included risks) under the Care Act should have been completed in line with current practice (discussed in paragraph 11.8.6). Within Adult Social Care files there was no clear evidence of the assessment of risk in relation to depression, low mood or suicide, even though these factors had been evident in case notes. From Adult Social Care records it was also not clear what steps were in place to mitigate risks particularly

[21] Buckner J et al (2019).
[22] South Gloucestershire Resolution of Professional Differences (Escalation Policy); March 2019

when monitoring indicated that they were increasing. All such risks should have been clearly documented and mitigated **(Learning point 9)**.

11.7 Treatment and support for Adult A

11.7.2 Health and Adult Social care professionals acknowledge that individuals like Adult A who experience ill health (both mental and physical) in connection with substance misuse are often extremely difficult to engage with and support. There is also an acceptance that positive outcomes are difficult to achieve even when mental health and substance abuse services have worked closely together. Despite these challenges all agencies in South Gloucestershire worked within current pathways to deliver care to Adult A.

11.7.3 Despite Adult A's insistence that support should be delivered in accordance with his own terms, and his lack of engagement, professionals persevered in their attempts to engage with him and support his needs. Within the community Southern Brooks and DHI in particular worked constructively together to arrange joint appointments to co-ordinate activity and this should be seen as good practice.

11.7.4 Adult A was supported by Southern Brooks family support team from 2015 until August 2018. During this time Adult A declined structured treatment programmes which meant that his needs had to be addressed within the community. This intervention included one to one, peer support and included elements of self-help such as the completion of a 'drinks diary'[23]. Adult A was also attending SMART[24] sessions (nine sessions - although his attendance wasn't always monitored).

11.7.5 Adult A also had the support of an Action Group between 06/06/18 -20/06/18 and he attended four sessions which focused on strengths, positive outcomes and problem solving. In group discussions Adult A advised his peers that he was reducing his alcohol consumption using the safe 10% reduction plan which he had been provided with. The evidence contained within agency records in relation to his drinking habits and levels of consumption clearly identify that this was not the case. On many occasions Adult A failed to attend the action group which was undoubtedly driven by the circumstances in which he found himself.

11.7.6 The level of intervention provided by the wellbeing worker allocated to his case by Southern Brooks should be seen as good practice. This support worker would take him to or reminded him about appointments and had signposted him to agencies. On occasions this worker would have contact with Adult A five or six times a week and they also attempted to provide him with structured activities such as work at an allotment. This individual provided a single point of contact and consistent support for him. There is evidence that they constantly re-iterated to Adult A that death was a real possibility due to the life choices that he was making. They also reminded him that the fact that he was constantly failing to attend appointments meant that he was in danger of losing the support that was offered to him. Despite this level of personal interaction and the professional relationship that had formed between them Adult A due to the complexities of his life continually failed to follow their advice.

11.7.7 In terms of Health intervention Adult A received support from primary services, hospital, drugs and alcohol specialists and SWAST.

[24] SMART (Self-Management and Recovery Training) is a programme that provides training and tools for people who want to change their problematic behaviour, including addiction to drugs, alcohol, cigarettes, gambling, food, shopping, Internet and others.

11.7.8 Adult A's GP would appear to have had regular contact with him over the twelve months, prior to his death through face to face and/or telephone contacts. The GP also appears to have been very proactive in contacting other agencies for support for Adult A including getting his permission to refer his case to Adult Social Care. There is also evidence of good liaison with Southmead hospital, SWAST and Adult A's support worker. Whilst this level of multi-agency interaction should be seen as good practice there were occasions where there was a failure by the surgery to return calls or follow up areas of concern that had been raised by agencies such as DHI or Adult Care. On the 17th December 2018 Adult A's Social Worker called him and as a result of the conversation that took place they were very concerned about his welfare. The social worker called his GP surgery and raised her concerns with the receptionist. They then asked if the duty doctor could call them. It would seem from the records held that this contact didn't take place. This should be considered as poor practice as all such referrals should be acted upon.

11.7.9 On occasions there was also an over reliance on Adult A being able to communicate with his GP. Many professionals took his word that he was doing so and that he was receiving the treatment that he needed. Whilst Adult A was urged to make urgent contact with his GP during several presentations professionals could have followed up their concerns (as identified in the DHI review report) (**Learning point 10 x ref recommendation 5**). Such contact may not have been required had a multi-agency meeting been in place where information could have been effectively shared and concerns raised (see section 11.8.24).

11.7.10 In terms of SWAST attendance this was in line with policy and practice and staff would appear to have dealt with Adult A sympathetically and treated him in accordance with his needs. On one occasion Adult A was seen by SWAST but refused admission to ED despite the efforts of both the crew and his GP. On this occasion Adult A was too weak to get any basic items of shopping so the crew carried this out for him. This was a compassionate gesture and should be seen as good practice.

11.7.11 On reviewing their records the SWAST report writer has stated that as Adult A was 'clearly unable to look after himself despite the assumption that he had capacity' and there were possible missed opportunities in relation to the GP visiting him at his home address. They identified this this could have occurred on at least two of the occasions when they had attended and made contact with them including the 23th November 2018. The GP has stated that his condition was being managed adequately in the community by Alcohol Services and that they were working with them to manage his welfare.

11.7.12 In relation to Adult A's treatment and support whist attending hospital there were two early attendances in 2018 where he was not offered a referral to Alcohol Liaison Team. Processes and policy are in place to do this and these were missed opportunities to provide the specialist support that he needed. The later encounters (following admission into the Emergency Department or when he was an inpatient) were appropriately referred (eight in total) to the team and his case overseen by an alcohol specialist nurse. All of the referrals to the Alcohol Liaison Team were followed up with information being shared with Adult A's GP. The level of support provided by the service would appear to have been proportionate and in line with current operational practice.

11.7.13 Following any referral to the hospital Alcohol Liaison Team, it is however important that additional action takes place within the community. The review has identified that were missed opportunities to proactively communicate with both Adult A's GP and DHI following hospital admissions to ensure that there was continuity in the treatment that was being delivered. Records show that whilst there was some information sharing this was inconsistent (17/11/18, 21/12/18 - Hospital Alcohol Team records). Again processes and policy are in place to enable this and they should have been followed.

11.7.14 All health agency records clearly document how difficult it was to manage Adult A particularly as he would often self-discharge when he was capable and able to leave hospital. Whilst attempts were made to persuade him to receive treatment Adult A would appear to choose to disregard them. There has been nothing identified during the review that would indicate that Health professionals could have done anything further to prevent this from occurring.

11.7.15 In this case medical professionals would appear to have acted appropriately in relation to Adult A's treatment whilst he was in their care although on the 21st December 2018 records show that he was "Not seen when on ward due to low priority and poor staffing'. On that occasion he was documented as an unmet need and his GP and DHI were not informed of this hospital admission. This would appear to have been the only time when his needs weren't assessed within the hospital setting.

11.7.16 This case has however highlighted that alcohol and medical services (community, specialist and inpatient) need to continue to develop pathways to help individuals who don't want or can't achieve abstinence. The DHI review writer has identified that whilst their own organisation has embedded a harm reduction approach this should be extended and would complement the current recovery model that is in place. In order to achieve this an alternative community response to high impact hospital users would need to be considered (e.g. a high impact pathway and assertive outreach could provide hospital in-reach, brief interventions and home visits to increase re-engagement which could prevent further hospital admissions) (**Learning point 11**).

11.7.17 From agency records It is unclear if Adult A was taking the medications that were prescribed to him and it is clear that he was unable to effectively look after himself. On reflection it was identified by those involved in the review that Adult A may have benefited from a daily package of care to support with medication and diet. No one agency could have effectively delivered this alone and therefore a co-ordinated multi agency response was required which will be discussed in the next section.

11.7.18 In terms of improving practice the DHI review writer identified that where a client, such as Adult A, is open to community services then an alert should be raised, and the client's case discussed in the AWP DHI referrals meeting. Where it is identified that a client is not currently engaged with services, then a new referral should be offered. This meeting would provide an opportunity to review cases of those clients who attend hospital on a frequent basis. This was an opportunity that was missed in terms of providing further oversight and possible co-ordination of services for Adult A (**Learning point 12**).

11.7.19 Throughout agency records there is evidence that individuals and agencies tried to deal with Adult A compassionately and that they listened to his views. His 'voice' is clearly recorded within the entries that have been made which is good practice.

11.8 Operational Practice, Policy and Procedure

11.8.1 Representatives of those agencies involved in this case have confirmed that robust policies are in place with regard to Adult Safeguarding and Self Neglect. These policies are available to staff through internal intranet sites and the external South Gloucestershire website although as this review as highlighted there is additional work that can take place to embed them into practice.

11.8.2 Although not specifically covered by the time scales for this review it is relevant to state that there were seven referrals made to Adult Social Care raising concerns (in relation to self-neglect) between 2014 and 2018, which were not progressed. These referrals were not progressed, either because there was insufficient information contained within them to indicate that Adult A had care and support needs that met the criteria for enquiries (S42) or because he hadn't consented to the referral. The fact that these referrals were not progressed ultimately led to a lack of co-ordination and an holistic overview of Adult A's case.

11.8.3 The South Gloucestershire multi-agency self-neglect guidance flowchart advises that if there is any concern about self-neglect, that contact should be made with Customer Service Desk to complete an initial inquiry. As previously stated the referrals that were made in 2017 should have been progressed even though consent was not forthcoming from Adult A. In this case decisions relating to thresholds were made with the perception that Adult A was 'choosing' to make unwise 'life style choices'. The South Gloucestershire Council Alcohol Strategy[25] recognises alcohol dependency as an illness, and it is vital that the self-neglect pathway acknowledges such an addiction as a valid care and support need **(Learning point 13**).

11.8.4 The training and awareness of staff at the initial point of contact within Adult Social Care is seen as pivotal in improving threshold decisions in cases involving alcohol dependency and neglect in line with current policy. In this case their knowledge and ability to make informed decisions was seen as a weakness in the process **(Learning point 14**).

11.8.5 Had there been an holistic overview of his case within Adult Care and case conferences held then the apparent risks which would appear to have been escalating would have been evident to all agencies. These risks included increasing self-neglect, the deterioration in his living conditions, increasing health needs, frequent unplanned admissions to hospital and the risk of death which had been raised by his GP.

11.8.6 In this case it would appear that safeguarding thresholds were not correctly applied[26] and that opportunities may have been missed to intervene at an earlier stage. In Adult A's case there was no evidence that an assessment[27] was conducted and this could have supported professionals in the decisions that they made. Professionals (Southern Brooks) had discussed the need for an assessment with Adult A on the 1st February 2018 and he had agreed that one could be completed. From the records held it there was also no rationale recorded as to why an assessment was not considered necessary by Adult Social Care in this case. The lack of a formal assessment should therefore be seen as poor practice.

[25] Draft South Gloucestershire Alcohol Strategy Document 2020-2025.
[26] Barnett (2017).
[27] A formal assessment of capacity includes assessing an individual's ability to understand the implications of their situation, take action to protect themselves from abuse and for them to fully participate in decision making about interventions.

11.8.7 Adult Social Care have identified that decision makers may not have fully considered their powers to make an assessment at the early ‘screening stage’. From a review of Adult Social Care records it would appear that decision makers were only focusing on the formal safeguarding process when considering Adult A’s eligibility for further enquiries or assessment. As Adult A didn’t meet the criteria as a vulnerable adult in the view of those assessing his case the benefits of an assessment were overlooked.

11.8.8 In reality the threshold for assessment is low (appearance of need for care and support) and had the full circumstances been taken into account then his case should have reached the point where further action was required. Even had the S42(1) criteria not been met then Adult Social Care could have suggested a non-statutory enquiry in view of the apparent risks (**Learning point 15**).

11.8.9 South Gloucestershire has made positive steps to improve practice through the implementation of the ADASS S42 Framework [28] (referral and assessment improvements), the 3 Conversations Model[29] (focusing on prevention and wellbeing) and through Making Safeguarding Personal[30].

11.8.10 When applying the 3 conversations Model against this case retrospectively it is likely that the first contact in 2014 from AFRS in respect of Adult A would have been progressed rather than being considered and ‘screened out’. Had such intervention taken place then the care and support package to Adult A could have been more effectively co-ordinated although it must be highlighted that the outcome may have remained the same.

11.8.11 Since this case Adult Social Care within South Gloucestershire have moved away from the language of ‘screening’ and all staff have been encouraged to record whether the S42(1) criteria has been met. Ultimately it is felt that this will ensure that the correct referrals are being accepted by the agency and this will improve transparency and accountability. Such changes to practice will need to be monitored to ensure that they are effective and fully embedded into practice.

11.8.12 In an attempt to address the issue of referrals having insufficient information and to prevent re-referrals from occurring all agencies in South Gloucestershire should ensure that staff are fully aware of the criteria required within S42 and that quality assurance practices are in place to identify effective compliance (**Learning point 16**).

11.8.13 From the documentation that was reviewed it would appear that the perceptions of professionals in relation to thresholds and their previous experience that in such cases action was unlikely to be taken, was a barrier to information sharing and effective safeguarding. The DHI review writer has stated that ‘*It is concerning that past professional experiences of facing challenges of getting a referral ‘accepted’ or receiving feedback is potentially influencing practitioners decisions to not make a referral’*. Adult Social Care must therefore develop a communication strategy to ensure that changes to practice are widely communicated and which will enable professionals in other agencies to feel confident in making referrals. There also needs to be increased awareness that the Customer Service Desk can be contacted for advice were concerns arise (**Learning point 17**).

[28] ADASS (2019)
[29] The ‘3 conversations’ model is an innovative approach to needs assessment and care planning. It focuses primarily on people’s strengths and community assets. It supports frontline professionals to have three distinct and specific conversations (SCIE;2020)
[30] Making Safeguarding Personal (MSP) is a sector led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. The work is supported by the LGA with the Association of Directors of Adult Social Care (ADASS) and other national partners and seeks to promote this approach and share good practice (Lawson ;2014)

11.8.14 In terms of process the safeguarding referral that was made by Adult A's GP on the 17th October 2018 was "screened in" on the 15th November 2018 and allocated to social worker on the 16th November 2018. The delay of one month between referral and allocation is outside the timescales recommended by South Gloucestershire Adult Care Services. This delay further hampered a co-ordinated approach in respect of Adult A's care [31].

11.8.15 The review has also identified that there was a month's delay between allocation of Adult A's case to a social worker and a strategy discussion taking place. The SAB Practice guidance[32] states that this should usually be completed within five working days. Adult Social Care should ensure that a quality assurance system is in place to monitor the timeliness of case allocation and strategy discussions and that this information is routinely scrutinised by managers (**Learning point 18).**

11.8.16 The case has highlighted that there were delays throughout the case which could be attributable to ill informed decision making regarding the issue of consent an senior practitioners not viewing the matter as a safeguarding concern or feeling that there was insufficient evidence of care and support needs. Social Care were also not proactively following up on the information provided by agencies and were relying on information being presented to them. There were also occasions where practitioners believed that they had made a referral (Housing Support Worker in 2018) whereas in fact the decision had been taken by the senior practitioner to take no further action. This decision would appear not to have been communicated back to the referrer leaving opportunities for Adult A to fall between services.

11.8.17 In terms of the help and support that was provided by Adult Social Care it is clear from agency records that the social worker who was allocated to his case worked hard to contact Adult A, in order to assess his case and offer support. They had also tried to contact Adult A's mother and other supporting agencies (GP, DHI) by phone. Despite repeated attempts the social worker was often unsuccessful (on review it was identified that some contact details were incorrectly recorded) and this prevented his case from being progressed. The Adult Social Care report identified that as a result of these failed attempts it would have been useful if other methods of contact including personal visits, attending the GP surgery's multi-disciplinary team meetings or email communication to allow a group discussion could have been considered.

11.8.18 Those within Adult Social Care could have also learnt from the experience of Adult A's community support workers. These individuals had a vast amount of experience and could have been used to inform the social worker on engagement strategies and how to best manage Adult A and his condition. This was a missed opportunity to learn from those that had cared for him over many years.

11.8.19 The review has also identified that there remains confusion amongst professionals as to whether cases like Adult A's could be referred direct to the drugs and alcohol service. Referral pathways to drugs and alcohol services therefore need to be publicised (**Learning point 19**).

11.8.20 On the 7th August 2018 Southern Brooks facilitated an multi agency exit meeting as it was felt that Adult A was in a cycle where he did not want to or could not change. Adult A attended this meeting and those present discussed a number of issues

[31] The author of the Adult Social Care report did however state that during this 'screening' process, the senior practitioner within the service had collected good information by speaking to, or attempting to speak to Adult A, and the key people in his life.
[32] SGSAB Multi Agency Procedures 2017

including low mood, isolation, risk of eviction and the risk of death. Safeguarding was discussed and it was felt by all that his case didn't meet threshold at the time. The notes from the strategy meeting had also stated that "There are no concerns about Adult A's ability to make decisions about his care and support needs". This statement had failed to acknowledge the concerns raised by Adult A's GP and the discrepancies raised by other professionals about his diminishing capacity to make informed decisions.

11.8.21 An opportunity was missed at this exit meeting (as identified by DHI) to share information with Adult A's GP and Adult Social Care. The review identified that Southern Brooks had believed that they had handed over Adult A's care and support to those other organisations that were working with him. As a Voluntary Community and Social Enterprise (VCSE) organisation who had tried to engage Adult Social Care during the management of his case Southern Brooks did miss the opportunity, at that time, to make a further referral. Following the meeting a referral should have been made to Adult Social Care.

11.8.22 The unintended consequences of this exit strategy and a failure to refer the matter to Adult Social Care meant that Adult A didn't have a key worker until his referral was accepted by Adult Social Care on the 15th November 2018, and this led to a gap in the holistic oversight and management of his case. This impacted on such issues as the effective sharing of information amongst all relevant agencies (Primary Care Team as detailed in DHI report 18/10/18).

11.8.23 The notes from the strategy meeting also state that there had been a number of unsuccessful attempts to contact DHI. Those carrying out the review identified that the calls had been made to a mobile number of a worker who no longer worked at DHI and no attempt had been made to make direct contact the DHI office. DHI has since ensured that all mobile phones and email accounts that are no longer in use have been deleted and reiterated the use of the DHI single point of contact.

11.8.24 There has been a clear recognition amongst all of those on the panel that in order to reduce alcohol related deaths from occurring in the future a multi-agency approach is required. In this case professionals (Southern Brooks, Police, and Adult Social Care) felt that multi agency meetings could have been held earlier. These meetings could have coordinated the delivery of services with an identified lead practitioner and a shared plan. In this case there would appear to have been a great deal of activity taking place but agencies weren't necessarily talking to one another which has been a reoccurring theme in SAR's nationally[33].

11.8.25 In terms of effective recording practices the Adult Care report identified that whilst there was some evidence of information gathering and decision making there were also entries that lacked detail. In some records there was a lack of analysis and reference to the six safeguarding principles[34] and legislation (Mental Capacity Act and Care Act). An example of this was highlighted in Adult Care records where references were made to mental capacity but the rationale for decisions was not articulated. This was particularly pertinent in respect of the concerns raised by Adult A's GP that he would die and it is unclear what action was taken to reduce that risk. This shows poor practice in terms of the recording of information and supervision.

[33] Braye et al (2015)
[34] Six safeguarding principles - The six principles of the Care Act are: Empowerment; Protection; Prevention; Proportionality.; Partnership; Accountability (South Gloucestershire website 2020).

11.8.26 Whilst Adult Social Care have started to address the issue of poor recording practices through the ADASS framework reflective practice (as seen within the Access Team) and the introduction of a Defensible Decision Making course that covers making legally literate decisions the service needs to ensure that quality assurance processes and supervision are robust (**Learning point 20**).

11.8.27 The review has also identified additional areas for improvement in relation to supervision and oversight within DHI. In this case the safeguarding concerns were not discussed with a DHI line manager and they were not added to the DHI spreadsheet until the safeguarding adult's strategy notes had been received. Had the concerns regarding Adult A been raised earlier with management then information could have been shared with Adult Social Care and a referral may have been accepted earlier. Clearer safeguarding advice to staff will ensure that there are not delays to information sharing with Adult Social Care. (**Learning point 21**).

11.8.28 As part of the review BrisDoc identified that they do not have easy access to Mental Health or Social Service records which, in this case, may have been useful in considering whether further intervention or multi agency working was required (**Learning point 22 – Recommendation 6**).

11.8.29 Adult A presented to Health services on numerous occasions. The panel have identified that it is unclear if there is currently a process for flagging multiple presentations on the hospital database. On review it was identified that there is a 'High Frequency Pathway' involving MDT members, the ED nurse, MHLT, Alcohol Team which meets monthly to discuss the top attenders. This should be seen as best practice. Adult A unfortunately did not trigger this process due to the fact that he wasn't in the top eight to ten cases. Where an individual like Adult A presents to hospital frequently in a short period of time, then this should trigger an enhanced pathway of support for pro-active follow-up by GP or community services.

11.8.30 Despite multi-agency working and frequent communication between agencies some agencies were unaware that Adult A had died. There was a long delay (nearly 3 weeks) before primary services informed his social worker he had passed away, despite her repeated calls to the surgery. Adult A's social worker had in the intervening period tried to make contact with him and had they contacted his family this would have added to their grief and would have been unprofessional. Current practices should have been followed in these circumstances and information shared with agencies.

11.8.31 Adult A's family were in contact with many of the professionals that were seeking to help him. The report writer for Adult Social Care identified that there was an opportunity to engage with them, seek their views, and perhaps develop a circle of support involving his family which had been missed by those working with him. Where appropriate families should be included and be central to the development of safeguarding plans **(Learning point 23)**. The importance of such contact was also reiterated by family members who stated that had they had contact they would have encouraged a more personalised but robust approach to the care of Adult A.

11.8.32 During this review the panel identified that professionals within Adult Social Care need clear and unambiguous safeguarding guidance for drug and alcohol clients who are at risk of harm or abuse. **(Learning point 24).**

11.8.33 The family of Adult A when reflecting on changes that could be made to current practice stated that they were asked to move Adult A's belongings out of his flat within two weeks of his death occurring. They felt that this was an insensitive approach at a time when they had many other issues to contend with. They have stated that Housing providers should work closely with bereaved families in such circumstances to minimise any unnecessary conflict and that a more flexible approach may be required.

11.8.34 In terms of improved process and structures the Police have identified that they have developed a unit (Lighthouse Safeguarding Unit) which provides a more streamlined approach to supporting vulnerable individuals. AFRS have four community safety workers in post and have also recently introduced a central triage team which can assess vulnerability and manage referrals.

11.8.35 Bromford Housing have also developed a localities approach and neighbourhood coaches that will improve client contact opportunities, promote proactive enquiries regarding vulnerable groups and increase multi agency working opportunities.

11.9 Training

11.9.1 Representatives of the agencies involved in this review have confirmed that training and awareness continues to be delivered to all staff in order to promote greater knowledge and understanding of adult safeguarding processes and self-neglect. In addition to other recommendations about training documented elsewhere in this report (11.4.11/1.8.4) AFRS have identified that additional training for the crews around self-neglect and mental health is required **(Learning point 25)**.

11.9.2 Adult Social Care have identified that they are continuing to roll out Making Safeguarding Personal training to all practitioners. This training addresses the issues raised in this review in relation to capacity and the need for consent. A specific recommendation is therefore not included in this report for additional training in this area.

12.0 Conclusions

12.1 Overall, there seems to have been a genuine effort on the part of professionals involved to engage and support Adult A over an extended period, albeit unsuccessfully to the point of being able to prevent his death. Clearly, there are lessons to be learned from the events that led to such a sad outcome and these have been reflected in the learning and recommendations in this report.

12.2 Adult A was unsuccessfully trying to manage his addiction within his home environment and despite the support that he was given he would repeatedly attempt detox against all professional advice.

12.3 All relevant agencies were engaged with Adult A but it was difficult to fully assess his needs and treat his condition due to his reluctance to consistently engage with services or enter structured treatment programmes.

12.4 Agency records clearly show that Adult A's capacity fluctuated according to the level of his drinking. As a result professionals differed in their view about his level of capacity and his ability to make informed decisions particularly in the months leading up to his death where there were frequent hospital admissions and his levels of self-

neglect increased. Professionals based their decisions on the fact that he had capacity as there were many days where, no matter how unwise his decisions were, he had the ability to clearly articulate his views. Although no formal assessment was ever completed it would appear from those that dealt with him on a regular basis that this assumption was correct. There has been nothing found during this review that would contradict this belief.

12.5 Although Adult A suffered from poor mental health there has been nothing found as part of this review that would indicate that he required statutory intervention as per the Mental Health Act 1983.

12.6 Whilst those professionals that worked with Adult A were aware of the risks associated with his lifestyle there were occasions when they should have been more responsive to indicators that these were increasing on occasions. In such circumstances a multi-agency assessment of risk and action plan to mitigate those that were identified would have been best practice.

12.7 Even if referrals had been acted upon earlier and multi-agency meetings established it is difficult to see how these would have changed the course of events that led to Adult A's death due to his level of engagement.

12.8 Current treatment and detox pathways for clients like Adult A need to be reviewed to ensure that they are flexible in the way that they are delivered and that they can meet current and future need.

12.9 Overall the review has identified that current policies that are in place to manage self-neglect and adult safeguarding but that additional work needs to take place to fully embed them into practice and quality assure their delivery. Additional work also needs to take place to improve detox pathways and provide clarity to professionals in those cases where individuals have complex needs. There is also a need to review and improve integrated treatment pathways to address mental health and addiction.

13.0 Learning and Recommendations

13.1 Below are learning opportunities that have been identified in this case. Only multi agency recommendations have been made and detailed in Appendix B. In relation to all other areas of learning these will be the subject of single agency progression and progress monitored through their own improvement plans.

- Learning opportunity 1 (Recommendation 1)

  There is currently no hospital detox pathway for individuals who are too unwell to detox in the community, or within inpatient facilities.

- Learning opportunity 2 (Recommendation 2)

  The availability of current alcohol treatment services needs to be extended to meet current and future needs.

- Learning opportunity 3 (Recommendation 3)

Where there are significant concerns about an individual's health, and it is suspected that their alcohol dependency may result in death, then an end of life alcohol pathway should be actioned.

- Learning opportunity 4 (Recommendation 4)

  Individuals are often unable to reduce their addiction without specialist mental health input, however, they are unable to access mental health services due to their dependency on the substance.

- Learning opportunity 5

  Adult A's self-worth and motivation could have been improved by using a strength based approach to his care.

- Learning opportunity 6

  Issues relating to consent and the ability to intervene in the lives of clients is not fully embedded into frontline practice within Adult Social Care.

- Learning opportunity 7 (Recommendation 5)

  There are continuing concerns that professionals in South Gloucestershire find the issue of consent confusing. Agency training needs to ensure that professionals are aware that referrals can be made to Adult Social Care without consent in appropriate cases.

- Learning opportunity 8

  Escalation processes are currently not fully embedded into practice.

- Learning opportunity 9

  In this case a formal risk assessment under the Care Act should have been completed in line with current practice and all risks should clearly documented and mitigated.

- Learning opportunity 10 (x reference with Recommendation 5)

  Adult A was urged to make urgent contact with his GP on numerous occasions but professionals could have followed up their concerns (direct with the GP).

- Learning opportunity 11

  Alcohol and medical services (community, specialist and inpatient) need to continue to develop pathways to help individuals who don't want or can't achieve abstinence.

- Learning opportunity 12

  In this case an alert should have been raised, and the client's case discussed in the Avon and Wiltshire Mental Health Partnership (AWP) DHI referrals meeting.

- Learning opportunity 13

The self-neglect pathway must acknowledge alcohol dependency as a valid care and support need.

- Learning opportunity 14

  The training and awareness of customer service staff within Adult Social Care is seen as pivotal in improving threshold decisions.

- Learning opportunity 15

  In cases of self-neglect, adult safeguarding decision makers and managers to ensure that there is a low threshold for rebutting the first principle of the MCA. Where a decision has been made not to carry out an assessment under the MCA, the rationale for this should be clearly recorded.

- Learning opportunity 16

  Current referrals submitted to Adult Social Care often have insufficient information and can lead to re-referrals from occurring all agencies

- Learning opportunity 17

  Historic threshold decision making has had a perverse impact on agencies making referrals.

- Learning opportunity 18

  The review has also identified that there was a month's delay between allocation of Adult A's case to a social worker and a strategy discussion taking place.

- Learning opportunity 19

  The review identified that there remains confusion amongst South Gloucestershire professionals as to whether in cases like Adult A's could be referred direct to the drugs and alcohol service.

- Learning opportunity 20

  Current changes within Adult Social Care (ADASS framework / Defensible Decision Making course) to address poor recording practices have yet to be fully embedded into operational practice.

- Learning opportunity 21

  Adult A's case would not appear to have been discussed with a DHI line manager and not added to the DHI spreadsheet until the safeguarding adult's strategy notes had been received. Had the concerns regarding Adult A been raised earlier then information could have been shared with Adult Social Care and a referral may have been accepted earlier.

- Learning opportunity 22 (Recommendation 6)

In order to improve service delivery BrisDoc identified that they do not have easy access to Mental Health or Social Service records.

- Learning opportunity 23

Adult Social Care identified that there was an opportunity for greater engagement with Adult A's family to seek their views, and perhaps develop a circle of support.

- Learning opportunity 24

The review has identified that Adult Social Care need clear and unambiguous safeguarding guidance for drug and alcohol clients who are at risk of harm or abuse.

- Learning opportunity 25

AFRS have however identified that additional training for the crews around self-neglect and mental health is required.

Appendix A - Summarised Chronology

The chronology date set for this review was from the 1st January 2018 to 31st January 2019 as these dates provide a sufficient time span that captures Adult B's deterioration in mental and physical health and the services that were provided to him by agencies.

Date	Circumstances
09/01/18	Complaints raised to Housing regarding Adult A sleeping on the staircase and burning food (denied by Adult A who stated he had only slept on the staircase once and that he used a microwave).
11/01/18	Adult A's support worker contacted his GP stating that he would not go out and would not see his DHI worker or a counsellor as he was down and depressed. Adult A felt paranoid and ashamed.
18/01/18	Adult A contacted Southern Brooks and stated that he was too ill to go out that day. He stated that he had been sick and that he couldn't eat anything. He was described as 'chuntering', speaking strange words and making strange noises. He was initially unable to remember who he was speaking to and had stated that he had lost his phone despite him using it. His support worker went to his GP surgery to report that he seemed confused. The GP spoke to Adult A who stated that he was better. He was offered a Health Visitor visit but declined all contact.
22/01/18	Adult A telephoned by the alcohol team. Adult A sounded intoxicated but stated that he was considering detox. He had high levels of anxiety around going into detox. He was also contacted by a DHI worker who discussed his risks.

25/01/18	DHI key worker contacted Adult A. He advised that he was drinking 1 litre of vodka per day. Adult A identified that alcohol had become more of an issue when his father died. The issue of ambivalence was discussed and he stated that he knew if he continued he would die. He reported social isolation and loneliness, with no friends and not being too close to his mum and brother. Southern Brooks spoke to Adult Social Care about referring Adult A's case. They were informed that Adult A would need to give permission.
25/01/18	Sothern Brooks contacted Adult A and he did not sound well. He said he had filled out some of the tables that BS from DHI had given him about his drinking habits. Adult A stated that he was not coping and he was asked to give me permission for them to contact Adult Social Care which he did.
01/02/18	Southern Brooks contacted Adult A. He said that he did not feel well. He was reminded that his case had been referred to Social Care and he was urged to allow them to do an assessment which he had agreed to.
07/02/18	Adult A's support worker contacted Adult Care to chase up the referral. They were advised that if he did not consent then the referral could not be progressed. Adult Care stated that they had spoken to Adult A but that he did not want help.
15/02/18	Adult A attended a one to one appointment. He appeared to be intoxicated and struggled to communicate clearly. Adult A had not kept drinks diary. Key worker tried to explore how Adult A could cut down however he did not engage. Key worker was unable to confirm goals/objectives and discussed with WH that he would need to have an aim to benefit from key working to which he agreed.
22/02/18	Record entry that Adult A was due to scatter his dads ashes.
25/02/18	Southern Brooks picked up Adult A who was described to be in a bad state and collapsed in the grounds of the flat. Some workers helped him into the car. Adult A was not showing any steps towards change.
27/02/18	Southern Brooks contacted Adult A who stated that he had bruised ribs and sore cheek which may have meant that he had and a seizure.
08/03/18	Records from Southern Brooks document that Adult A was unable to attend appointments as he was intoxicated and was not able to hold a conversation.
13/03/18	Southern Brooks phoned Adult A who was described as not being in a good state. He said he was ashamed and did not want to be seen. It was suggested that they phone Adult Social Care but he would not accept their help due to his sense of shame. It was described how the conversation went around in circles because although he felt isolated and ill he would not take any steps towards help. DHI would not see him in his current state.
22/03/18	Adult A attended a 1:1 appointment with a DHI key worker. He stated that he stopped drinking suddenly on 12/03/2018. He reported that he had the shakes but felt better at the time of the call. His key worker discussed the risk of stopping drinking suddenly and advised him that if he felt unwell then

	he needed to contact his GP or 111. Adult A could not identify a clear goal with regards to alcohol and did not want to remain abstinent but in would drink in 'moderation'. The key worker discussed attendance at the Relapse Prevention Group but Adult A stated that he did not want to attend. The key worker also discussed AA. Again Adult A stated that he didn't want to attend. The AA free phone number given to him.
12/04/18	Adult A attended 1:1 appointment with a senior DHI care worker. He reported attending counselling which he stated helped him. He advised the professional that he did not see another "single human being" unless it was his interaction with professionals. He stated that he did not go out alone. Adult A reported that he was feeling unwell and often retched and felt sick. He also stated that his sleep pattern was poor as was his diet. He was urged to see a GP as a matter of urgency. His key worker reviewed his structured support with him- Adult A had completed his 6 x 121 sessions and still did not have a clear goal or made changes. Adult A advised his key worker that he wanted to be able to drink occasionally and saw" nothing wrong with an occasional drink". A plan of action was agreed.
18/04/18	Notes from GP stating that Adult A often forgets to take his medication and that his dosset box hadn't been collected. It was noted that his key worker would collect it and take any old medication away from his home.
26/04/19	Phone call from Southern Brooks to Adult A and he advised them that he had drank an unspecified amount of alcohol on the previous day that had made him vomit. He was advised to see his GP.
03/05/18	Adult A attended a 1:1 appointment with senior DHI care worker. He had completed some days of his drinks diary and risks were discussed. Key worker advised Adult A to see his GP for a health check. Adult A did see the GP as agreed but only regarding athletes foot. Plan of action agreed.
22/05/19	Adult A attended a 1:1 appointment with senior DHI care worker. Adult A could not identify goals related to alcohol. Adult A reported he had not drunk for 4-5 days. Keyworker discussed the risks involved with stopping alcohol suddenly including the risk of death. Adult A reported that he regularly felt sick. He was encouraged to attend to see his GP for a health check. Plan of action agreed.
22/05/18	Multi-agency professionals meeting held involving, Southern Brooks, key worker, housing officer, DHI key worker. The meeting was arranged to discuss discharge of client as they will be closing service end Aug 2018. Areas of concern: low mood and relapse to alcohol; risk of isolation and death, risk to property through fire , risk of eviction; client not attending appts; whilst intoxicated client falling asleep in shared stairwells in his flat causing concern to other residents, and property was in a poor state. Safeguarding discussed - all present agreed that client would not meet threshold. Action plan agreed.

25/5/18	Key worker missed call from Adult A. Key worker returned call. Adult A stated he had relapsed. Key worker asked Adult A if he was suicidal - he stated no. Key worker gave the number of the Samaritans.
31/05/18	Adult A attended 1:1 appointment with Southern Brooks worker. He reported that he was drinking up to 1 litre of whisky p/day for the last week, and that he had 4 or 5 shots that morning. He stated that he was not heavily intoxicated. His key worker discussed the plan for Southern Brooks support to end in August 2018. On asking client what his goals were with his alcohol use he replied, "I will always be a drinker" and " don't know". Adult A stated he would like to access to rehab and was advised of the pathway. He then said, 'forget about it'. His key worker felt adult A was too intoxicated to continue with meeting. Action plan agreed.
21/06/18	Key worker phoned Adult A and he stated that he wasn't well. Adult A was retching consistently throughout the phone call. He advised the key worker that he had drank 1/4 bottle vodka yesterday but was not drunk that day as he couldn't stop vomiting. Adult A was advised to make a GP appointment or call 111. The risks including possible fatality of alcohol withdrawal were discussed with him. The key worker was concerned for his health and stated that they would like to arrange the GP to call him. Adult A agreed. The key worker called the GP surgery and was advised that a call would be made that day. The GP called Adult A but he declined an appointment due to the fact that he couldn't get there and that he wanted to see how he felt the following day.
22/06/18	Key worker spoke to Adult A who stated that he would not make a further GP appointment as he had no credit to call and didn't like doctors stating it is "a phobia". Adult A added that he was feeling better and does not think it necessary. Key worker advised Adult A that if he felt unwell he should call 111 or 999.
25/07/18	Southern Brooks contacted Adult A. He seemed low and was still drinking heavily. He was given information about Avon North Intergroup meetings. Details provided later that day of someone who had previously overcome addiction who Adult A could have spoken too.
02/08/20	Southern Brooks spoke to Adult A who said that he was not feeling very well. He said that he had not been drinking as much but did not want to talk about what he had been drinking. He said that he had no appetite and was just drinking milk and water and was not eating solid food. His brother and mother had bought some milk and food on his behalf but he had not felt well enough to go with them. He stated that he had not been unable to go out. He could not remember if the people from AA had got back to him.
13/08/18	DHI contacted Adult A's key worker (Southern Brooks) to advise that his case would be closed due to non-engagement. The key worker advised that Adult A would like to continue with his attendance at the Action Group. The key worker was advised that DHI needed commitment from Adult A. It was

	identified that he had missed four consecutive groups. Adult A asked to contact DHI within the next 7 days, in order for him to restart the Into Action Group. If Adult A failed to do this then he would have been offered support from the SMART group.
16/08/18	DHI key worker called Adult A who advised them that he was feeling unwell and that he had not been able to drink any alcohol for a few days after a period of vomiting. Adult A was urged to call 111 or attend GP urgently as he may be at risk of a fit which could result in life altering consequences or death. Adult A confirmed he understood this and stated that he had been this before. His goals were reviewed and he stated that he wanted to continue social drinking. Adult A stated that he found it difficult to attend groups however he recognised that he needed to attend to get support. On asking Adult A what support he would like from DHI he advised them that would like friends. Key worker advised that DHI staff are "friendly professionals and not professional friends", and they discussed AA. Adult A encouraged to seek medical help and invited to re-start Into Action Group.
22/09/2018	999 call from Adult A who stated that he was drinking a minimum of a litre of spirits (vodka or whisky) daily and had that he has been a heavy drinker since he was 16 years old. He stated that he had stopped drinking suddenly 2-3 days prior to this call as he wanted to stop drinking. Since stopping Adult A had severe vomiting and when trying to drink fluids or eat he was vomiting straight away. Adult A had severe abdomen pains that meant he couldn't stand up straight and struggled to mobilise. Adult A had also been having cramps in his hands and feet with loss of sensation in his feet on occasions. Adult A conveyed to hospital and was diagnosed with alcohol withdrawal syndrome. Adult A self-discharged on 24/09/18.
24/09/18	Adult A called NHS 111 complaining of having the shakes, hallucinations and feeling dizzy. NHS 111 passed case to BrisDoc. Two attempts made to contact Adult A but it calls went to voicemail. The case was closed.
25/09/18	Adult A called NHS 111 complaining of having hallucinations. NHS 111 passed case to BrisDoc for him to speak to a clinician. Adult A spoke to a GP. After a 50 minute consultation during which the Adult A explained about his admission, a suicide risk assessment was undertaken, and capacity was considered. The GP decided to call 999 as Adult A was reticent about presenting to A&E. Adult A conveyed to Hospital. Referral made to alcohol liaison team.
26/09/18	DHI key worker contacted by Adult A from hospital. They discussed plan for support. It was is not clear from the conversation if Adult A wanted to make changes and they discussed that attendance at the action group had been sporadic. SMART attendance was left open for support. They discussed that if he wanted to re-enter structured treatment then he could call either his key worker or the DHI office. Adult A advised that he "respects" this pathway, and that he may need some time to recover and think about his choices with alcohol.

17/10/18	999 call from Adult A for low potassium levels. Adult A had been to the chemist for his dosette box but they wouldn't dispense it due to GP wanting to see Adult A. GP did a blood test and then called Adult A to say they were concerned with the results so arranged an emergency ambulance to transport him to hospital. Adult A had been self-detoxing for a week.
17/10/18	Adult A was referred to alcohol liaison team by medical assessment ward. Presenting illness was recorded as 'electrolyte imbalance' and admission due to alcohol. Assessed on ward, referred to AA, alcohol services and GP informed of admission. Records document that Adult A was aware of the risks of continued alcohol use and that he had some short term memory complications and ongoing numbness in feet. Professionals reinforced the need to engage with support and maintain and adequate diet. Treatment and support plan put into place.
17/10/18	GP spoke to Adult A and sought consent for an Adult referral to which he agreed. Concerns about self-detox and risk of salt disturbances in the blood. Letter from Adult A's GP, making adult safeguarding referral, expressing concerns due to self-neglect, alcohol dependency and electrolyte (salt) disturbances. Requesting social care package.
22/10/18	SA1 form (safeguarding alerter form) received by Adult Social Care from Adult A's GP. Concerns as stated above.
06/11/18	GP spoke to Adult A on the phone and he was out with his brother and feeling well. GP explained that his potassium levels were low. Adult A stated that he definitely did not want to go back into hospital even though the GP told him that he could have an irregular heart beat which would be very serious. Adult A stated that he wanted to remain at home. Adult A advised that if anything changed then he was to call back.
13/11/18	GP unsuccessfully tried to contact Adult A following continued concerns as raised above. A message was left on answer machine.
14/11/18	S42 information gathering started by Adult Social Care. Their notes indicated that the information on SA1 was not sufficient to explain the current level of risk. Attempted contact with Adult A - message left to call back before they then spoke with Southern Brooks Support Worker .
15/11/18	Screening Assessment concluded by Adult Social Care: Attempted further contact with Adult A - no answer. The social worker spoke to Support Worker at Southern Brooks and they attempted contact Adult A's brother - number not connecting. They also attempted contact with Adult A's mother which came up as a dropped number. The social worker also tried to contact his GP surgery - number just ringing out. Adult A's case was screened in for welfare check due to previous history.
16/11/18	Allocated to Social Worker in Adult Social Care in order 1 to complete Enquiry. Contact made with his support worker who did not feel that Adult A had a learning disability diagnosis or a mental health diagnosis.
17/11/2018	999 call made by Adult A to SWAST as he had fallen over and was bleeding. He reported that he was not taken his medications and that he was feeling increasingly unwell. He had been persistently vomiting. The crew found

	Adult A slumped against the wall outside of his flat, alert, orientated, advising he had not eaten for "days". Adult A was assessed in the ambulance and denied any drug use. Adult A was taken to hospital but had self-discharged prior to being seen.
19/11/18	Social Worker attempted to phone Adult A, no answer.
19/11/18	Referral made to Alcohol Specialist Nurse following Adult A's presentation on 17/11/20.
23/11/2018	999 call to Adult A via the GP due to welfare concerns as he didn't attend a blood test that morning and the GP was unable to contact him over the phone. On arrival of the SWAST crew they were met by Adult A outside his flat door, smelling strongly of vomit and he was pale and shaky. Adult A stated that he didn't need or want an ambulance. He stated that he hadn't attended his blood test that morning as he was vomiting and felt too weak and unwell. Adult A wouldn't let the crew into his flat due to 'the smell'. The crew spoke to GP who in turn spoke to Adult A. He was advised to attend hospital but he again refused. Whilst waiting for GP call back the crew went to the shop for Adult A. Safety netting advice given. Adult A's capacity was assessed and he was deemed to have capacity. The crew explained to Adult A that his heart rate and blood pressure were high and this had the potential to be dangerous if it continued. Also explained that he had the potential to have an alcohol withdrawal seizure which would be dangerous as he lived on his own. Adult A refused to be taken to the hospital.
23/11/18	GP was concerned that Adult A had not collected his weekly dosset box from the chemist and the GP could not contact them. The GP asked the Social Worker to call them and the police were asked to complete a welfare check. The GP received a phone call from a paramedic who had been tasked with the welfare check. They stated that Adult A looked very pale and had been vomiting. Adult A had not drunk alcohol since the previous day. There was no food/drink in the house so the paramedic brought some for him. Adult A had declined admission to hospital and was deemed to have capacity. GP strongly advised Adult A to go to hospital but he declined. He stated that he would call 999 if he felt that he was becoming more unwell.
26/11/18	GP spoke to Adult A who said that he was feeling better. He had managed to eat and had kept it down. He had not drunk for three days. Notes state that he understood the risk of refeeding syndrome (refeeding syndrome is a syndrome consisting of metabolic disturbances that occur as a result of reinstitution of nutrition to patients who are starved, severely malnourished or metabolically stressed).
27/11/18	Social worker spoke to Adult A on the phone. A visit was arranged for 7th December 2018 (which had to be cancelled on the day due to his social worker being sick). Adult A indicated that he was 'doing bad' and that he was embarrassed about the state of his flat. He said he had been ill and had not left flat for 5 days. He said he was experiencing anxiety about going out and seeing people.

30/11/18	Adult A- contacted by his social worker. Adult A said he was feeling better and had been outside. Social Worker spoke to the GP and discussed the initial safeguarding referral. The GP stated that they were worried about him dying alone in his flat. The GP gave a brief outline of the risks.
06/12/18	GP contacted Adult A. He stated that he was not drinking. It was his birthday that day and he felt 'quite upset and lonely'. He also stated that he didn't deserve any support or help. Action plan put into place re medication and support.
11/12/18	Social Worker phoned Adult A and rearranged home visit for 13/12/18.
12/12/18	Adult A contacted NHS 111 concerned that he had been told his heart could stop because his potassium was so low and he was having some chest pain. He declined admission and said he understood the risk of his heart stopping. Adult A was asked if he would agree to an ambulance being called. He declined.
13/12/18	Home visit attempted by Adult Social Care- Adult A did not answer the door or answer his mobile phone. The social worker informed the GP.
17/12/18	Safeguarding strategy discussion held with social worker and a senior practitioner. Adult A's case was tentatively assessed as medium risk, and the outcome was that a visit needed to be completed to assess level of risk and protective factors. The social worker also spoke to Adult A on the phone. He said he was too ill to answer the door or the phone during attempted home visit on 13/12/18. The social worker offered to call Adult A an ambulance, but he refused this several times during the conversation. Adult A advised he had been bingeing on vodka and that he found this time of year very hard. Adult A advised he planned to get his life sorted in January. The social worker passed on his GP's concerns that his blood tests are very important when he was unwell and offered to visit to see if she could arrange support. Adult A declined a visit. He advised that his brother was visiting the following day to take him to see his father's headstone, which he hadn't seen yet. Social Worker contacted Adult A's GP Surgery but they were not working.. The surgery stated that they would call the Duty Doctor to discuss the case. It would appear from records that this conversation did not take place.
20/12/18	Social Worker called Adult A, who asked her to call him after Christmas to complete a home visit.
20/12/18	BrisDoc professional line called by Southmead Biochemistry lab to report low potassium result for Adult A. Successful contact made with Adult A but he refused to go to hospital. He said he understood the risks and terminated the call. GP contacted with request for an urgent follow up visit.
21/12/18	Adult A contacted NHS 111 concerned that he had been told his heart could stop because his potassium was so low (he was declining admission) and he was having some chest pain. NHS 111 passed case to BrisDoc for him to speak to a clinician. Adult A was called back and successful contact eventually made by an Advanced Nurse Practitioner (ANP). Adult A was

	intoxicated (having drunk for the first time in 5 days) It was explained to him that his potassium was low and that he should go to hospital. Adult A declined admission and said he understood the risk of his heart stopping. The ANP called 999 for an ambulance to attend and transport him to hospital if he would agree.
21/12/2018	Adult A called 999 for chest pain and low potassium. Adult A stated he was contacted by his GP that day and was told to go to Hospital due to abnormal blood results. On arrival the ambulance crew found Adult A lying on floor, alert and pale. He was verbally aggressive and unpredictable. The crew were unable to gain any clinical observations as he was non-compliant. Initially Adult A refused to go to hospital and then physically assaulted a crew member. A second crew was dispatched with Police. On arrival of the crew the Police had to forced entry to Adult A's flat. Adult A was on the floor in the living room, appeared intoxicated, alert, normal breathing, good colour. Again the crew were not able to get a full set of observations or do an ECG due to Adult A being uncooperative. Adult A stated that he had not had a drink for five days as he wanted to quit however stated he had been drinking for 24hrs.The crew encouraged Adult A to go to Hospital. On attending hospital he was referred to alcohol team by the medical assessment ward. Records state the he was "Not seen when on ward due to low priority and poor staffing. He was documented as an unmet need. His GP and DHI were not informed of this hospital admission. Client was signposted to peer support at the hospital.
23/12/18	Adult A made a 999 call due to vomiting, abdominal pain and palpitations. Adult A had pancreatitis and stated his pancreas was "f****d". He was also complaining of chest pain. Adult A was intoxicated but denied recreational drugs. Adult A stated that he wanted to go to A&E. At hospital he refused to go inside and started having an anxiety attack.
31/12/2018	Adult A made a 999 call as he was suffering with ongoing abdominal pain. On arrival of the crew he was slumped against a wall in the lobby of the block of flats. Adult A was described as alert but pale. He described recent rapid weight loss and that he had not been eating for a few days. He was transported to hospital. Once there he was offered a referral to the alcohol liaison team. He was unable to be initially seen due to being intoxicated and then he refused to see them. He was advised to see his GP regarding depression. Follow up plan included contact with DHI worker.
31/12/18	Telephone contact with Adult A was made by a DHI Service Manager. Adult A was advised that they were sharing information with his social worker. Adult A explained that he was unsure about returning to SMART as felt embarrassed as the last time he had attended. Adult A was encouraged to consider returning to SMART and advised of additional support available to him if he wished to engage in treatment services. Adult A was reluctant to engage in support at that time and stated he would consider it in the new

	year. Adult A advised that he did not want contact with anyone at the moment, including his mother.
04/01/19	Social Worker attempted to call Adult A but there was no answer.
09/01/19	999 call to Adult A who had been found by a family member, laid on the front room floor with dried vomit around his mouth. Rigor mortis was evident.
09/01/19	Telephone call between social worker and Drug & Alcohol Worker from DHI. Social Worker spoke about the difficulties she was having in contacting Adult A and advised that if she could not meet with him she may have to signpost him to DHI for support as they have a pre-existing relationship with him.

Appendix B – Recommendations

Recommendation No.	Recommendation	Lead Agency
	Multi Agency	
1	It is recommended that a review is conducted of current detox pathways to establish the viability of direct referrals to hospital.	BNSSG CCG & Public Health DAP
2	It is recommended that a review is conducted of current capacity and the viability for the Alcohol Team to extend provision to seven days a week and increase out of hours cover.	BNSSG CCG & Public Health DAP
3	It is recommended that current policy and practice is reviewed to ensure that end of life pathways are included in any treatment pathways for appropriate alcohol dependant client cases.	BNSSG CCG & Public Health DAP
4	It is recommended that the pathway between treatment services and mental health services should be reviewed and a dual diagnosis strategy developed and implemented.	BNSSG CCG & Public Health DAP
5	It is recommended that current operational practice and training strategies are reviewed in relation to information sharing, the issue of consent (in terms of its effect on making referrals to ASC) and the interaction with GP services.	All agencies within SG partnership.
6	BNSSG CCG and Adult Social Care to consider a review the viability of BrisDoc having access to Health and Social Service records.	BNSSG CCG and Adult Social Care

Glossary

ADASS –	Association of Directors of Adult Social Services
AFRS –	Avon fire and Rescue Service
AMHP –	Advanced Mental Health Practitioner
ANP -	Advanced Nurse Practitioner
AWP -	Avon and Wiltshire Mental Health Trust
DAP -	Drug and Alcohol Programme
DHI –	Developing Health and Independence
DoLs-	Deprivation of Liberty Safeguards
GP -	General Practitioner.
GSC -	Government Security Classifications.
LSCB –	Local Safeguarding Adult Board
MCA -	Mental Capacity Act.
MHT -	Mental Health Team.
SAR -	Safeguarding Adult Review.
SB-	Southern Brooks
SGSAB -	South Gloucestershire Safeguarding Adults Board
SMART -	Self Management and Recovery Training
SWAST –	South West Ambulance Service Trust
VCSE -	Voluntary Community and Social Enterprise

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