Manchester Safeguarding Partnership

Self Neglect Thematic Review

This report was commissioned and prepared on behalf of the Manchester Safeguarding Partnership

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Contents

1. Introduction

1.1 This Thematic Safeguarding Adult Review (SAR) was initiated in 2018 by the Manchester Safeguarding Adults Board (MSAB), now called Manchester Safeguarding Partnership (MSP). The death of three adults at risk were considered together and all feature aspects of self-neglect. One of the three individuals' initially considered for a SAR was subsequently reviewed as an individual SAR. The two remaining were commissioned to be reviewed as a thematic SAR. To this end the first meeting of the review team was in March 2019 to look at the circumstances of these two individuals.

1.2 However, in the latter stages of the review another death was considered by the MSAB and this was added to the thematic review in September 2019. Pseudonyms are used throughout and the three individuals are Paul, Karl and Jane. It should be noted that the review in relation to the latter addition (Jane) is simply a desk top review on the preliminary papers made available by MSAB. This has not undergone the same level of scrutiny by the review team given that much of the analysis work of the thematic review had already been progressed.

1.3 **Why are these cases being reviewed?**

1.4 Safeguarding Adults Boards are required to consider if SAR's should be conducted in certain circumstances. A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame but capture positive learning to improve systems and professional practice for the future.

1.5 In making a decision to initiate a thematic SAR, MSAB complied with the Care Act 2014, the main provisions of which came into force in April 2015. Under the Care Act, Safeguarding Adults Boards (SAB's) must initiate a SAR when an adult in its area **with needs for care and support dies or suffers significant negative impact as a result of serious abuse or neglect (known or suspected), and where there is concern that partner agencies could have worked more effectively to protect the adult (The Care Act 2014, section 44).**

1.6 An independent lead reviewer was appointed by MSAB to facilitate and lead the review.

1.7 It should be noted that for legitimate reasons the Covid 19 pandemic has had an impact upon the progression of the thematic review. There had been three review meetings by the time of the pandemic emerged but following up final lines of inquiry were inevitably delayed thereafter for legitimate reasons.

Timeframe

1.8 It was agreed for this review that it would be helpful to focus on a period of a year prior to the deaths. Appraising the work of agencies further back in time is unlikely to achieve useful learning, given the inevitable changes in personnel, local arrangements, national guidance, regulations and legislation but that is not to say that more historical information has not been captured where the context is important. The review team have taken a proportionate approach.

Methodology

1.9 There is no prescriptive methodology for a thematic SAR though it is now widely accepted that for multi-agency reviews a system-based approach and methodology is desirable. There are a number of system methodologies that can be deployed but for this review it was agreed it would be helpful for systems learning methodology to be used.

Independence and expertise

1.10 The lead reviewer, Deborah Jeremiah is accredited in systems learning and is an experienced independent investigator across serious case reviews, safeguarding adult reviews and domestic homicide reviews. She is a safeguarding lead and works nationally. Deborah has a health, legal and governance background and has also worked on high profile national public inquiries.

Review Team

1.11 The lead reviewer was assisted by a review team of senior strategic professionals from relevant agencies within Manchester Safeguarding Partnership

1.12 The review was also assisted by a group of frontline professionals across all the relevant agencies who mainly had direct involvement with Paul and Karl. There was a practitioner event held. This brought important information to the review to best understand the professional responses at the time but also the current systems of working.

1.13 The families of Paul and Karl were afforded the opportunity to input into the review. The family for Paul provided rich and helpful information into the review which is woven into the report. The review team wish to record their thanks to Paul's family. Many attempts were made to involve Karl's sister and while she

initially expressed interest into inputting, subsequent attempts to engage her were unsuccessful.

1.14 The thematic review looked primarily at the circumstances of Paul and Karl and also latterly includes a desktop review concerning Jane. This report sets out below case summaries for each individual.

2 Case summary-Paul

2.1 Paul was a 74 year old, retired professional man who died at home in April 2018. He was found by his daughter after she was unable to reach him by phone.

2.2 Paul had moved to a privately rented flat in Manchester following a marital breakdown with his second wife. This was a major life event for Paul.

2.3 Paul had a caring family who lived in other parts of the country and they were in touch with Paul regularly. Paul had moved into the flat in some haste as the tenancy on his previous property ended but the flat was not ideal for him as he had sight, mobility and mental health needs. Paul was also dependent on alcohol. Paul started to self neglect.

2.4 Paul found mobilising challenging and lived in the cold and dark at times as he could not organise himself or go to top up his electricity. Paul was retired but was financially independent. The condition in his flat worsened resulting in him living in squalor with unsanitary conditions. His nutrition was poor and he had pressure sores and at times was doubly incontinent. He also suffered with cellulitis. Paul hurt himself a number of times as he had a tendency to fall. Paul was unable to empty his bins as he could not get down the steps outside his flat to reach them. His family would visit him and they reported the flat would be in a state with rotten food and their father sat in his own excrement. Paul could not go out so he was very isolated.

2.5 Paul had been hospitalised some weeks before his death and this was one of many times that he had attended the hospital. He was a frequent attender. He was generally taken to the hospital following falls. He also had a number of medical problems -some of these were of a serious nature, such as vomiting blood and sepsis.

2.6 Paul's family consider his mood was low but that he lacked insight into the severity of his alcoholism and health problems and he lacked motivation and the ability to care for himself. While he had at least 8 admissions to hospital he was discharged on each occasion without safeguarding measures in place. This was despite the family raising safeguarding concerns, as did the ambulance service.

2.7 On another hospital admission in late 2017 there was to be a High Risk panel meeting at the hospital at which Paul was going to be discussed. His daughter wrote a lengthy letter for this meeting highlighting the grave nature of Paul's situation and health problems expressing real fears that her father would tragically die and that he was in a "revolving door" of admissions, with no change or longer term improvement for Paul in his home environment or with his health. The family (some of whom are experienced medical professionals) advised that they believed that Paul's mental capacity fluctuated.

2.8 The family requested a number of agencies to help Paul, to rehouse him, and for him to receive services around his alcohol addiction; mental health challenges and other self neglect factors. An assessment was planned but this was not successfully completed as Paul became upset with the professional discussing his situation and she left.

2.9 Paul was found deceased by his daughter at his flat and the family feel strongly that with the right support Paul's death was avoidable.

2.10 Case Summary –Karl

2.11 Karl was a 53 year old man with epilepsy and used a wheelchair to assist mobility. He was prescribed important medication for his health conditions but he was not always compliant and would forget to take his medication. In 2017, health services arranged a drop off at home service for his medications to seek to resolve this problem.

2.12 Karl had an enduring and severe alcohol dependency with physical complications of this. He lived alone in rented accommodation. Karl received benefits and professionals had observed he did not have light or electricity in his home at times. There was also rodent infestation at periods. Karl self neglected at home and his sister reported he was struggling to cope and was unsafe. He suffered numerous seizures and falls at home sustaining injury and his health was unstable.

2.13 There was also a longstanding and significant safety issue in that Karl could not keep himself safe in his property as others would enter and at times harm him. This involved a range of people including other drinkers who he sometimes let in and then other individuals who entered the property against Karl's wishes and it would appear he was placed under duress at times to let people enter at will. There was also

evidence that he was being exploited for money and that his possessions including his cash card stolen. It is unclear if the property was used for illegal purposes but the situation in type and nature of home invasion upon Karl as a vulnerable person can be termed as “cuckooing”.

2.14 Karl had numerous admissions to hospital for seizures and falls in the main. In May 2017, a hospital social worker was able to secure a placement for Karl to a nursing care placement to a care home which had a special dispensation to take people under the age of 65. It is unclear under what legal or funding framework this was arranged but Karl was deemed to have the mental capacity to consent to be discharged from hospital to the placement. What we do know is that this was a social care placement and not one made under NHS Continuing Health Care where a holistic assessment is undertaken across all care domains and where a person may be eligible to access health care and services in their home or in a care placement funding by the NHS. Karl is recorded to have had schizophrenia, from a hospital record, however, there is no other reference to this in any other record. On discharge from hospital in December 2017 the consultant reported Karl as having a history of schizophrenia and non compliant with medication. Also one of the nursing staff reported Karl to be on medication for alcohol withdrawal and was intermittently confused. A mental health assessment was postponed by the mental health team until Karl was medically fit and his physical health had returned to its optimum. There does not appear to have been a formal mental capacity assessment taken at this point.

2.15 It is stated in the SAR chronology that Karl was discharged to the placement, but on closer enquiry he did not go the placement but in fact self discharged from hospital to home on 19th December 2017 with some medication.

2.16 Karl continued to self neglect at home and have problems with others coming into the home and he was seen by various services. In December 2017 having sustained a head injury following another fall/seizure requiring intensive care, his sister reported that a female pretending to be her called at the hospital and staff gave the female the key to Karl’s flat. The police checked the flat and it was blood stained due to Karl’s injuries but all property was present. The key was not recovered from the female.

2.17 During the same admission a CT scan of Karl’s brain showed global brain atrophy disproportionate to his age. His physical condition at this time was very poor and he was also hypothermic and had pneumonia on admission. His kidney function was also compromised.

2.18 Karl's GP also reported that Karl was not under mental health services. He was prescribed medication in the community for alcohol withdrawal and was described as intermittently confused. It was initially planned that he would have a formal and full mental health assessment during this hospital admission but he was not at baseline and so this was deferred. He was subsequently discharged home. It was arranged that he have an emergency alarm and that he would have a dispenser with an alarm on to remind him to take his medication.

2.19 While Karl was considered to have alcohol dependency and a suspected mental health condition he was not seen in the context of having a dual diagnosis. Dual diagnosis is the term used to describe a condition of suffering from a mental illness and a substance abuse problem. The one condition can complicate the other and it can be challenging for professionals to manage the complexity it brings to an individual. Either condition can vary in severity and fluctuate and requires dual care pathway. This care pathway is usually led by mental health services or a dual care pathway specialist and an opportunity was missed when the mental health assessment did not take place in hospital or followed up in the community. This is likely to have been due to the recording of schizophrenia by the hospital consultant being inaccurate and other agencies being clear that Karl did not have schizophrenia.

2.20 Further hospital admissions ensued and Karl was admitted again in March 2018 after being found on the floor by his sister. He was discharged and was due to have a medical assessment for his benefits but he was unable to get there. Karl had not been prepared to stay in hospital longer for further treatment or to see the alcohol nurse. The GP said he would arrange for an assessment in Karl's home. A s42 inquiry under the Care Act 2014 had been recommended but not completed.

2.21 For some reason Karl unplugged his emergency alarm on 5th April 2018 and stated he did not want this. The social worker therefore ended the contract for this at his request. It is unclear why Karl stopped using this or if he was having to pay for this service.

2.22 On 13th April 2018 Karl reported a theft from this home naming the same female who he and his sister had raised concerns about previously as the perpetrator.

2.23 This was the same female that his sister believes had taken his key. The police also received a call from Karl's friend reporting he was very vulnerable and without heating and electricity, They described the flat as "everything was broken; the TV was

on the floor and the house a mess." Karl reported to the police that if they came to visit he was too scared to open the door as he was being harassed by a male.

2.24 The next day, Karl's sister expressed grave concern about Karl and the female entering his home, taking money and that Karl has been taking a foreign substance from the female and she wanted the police informed. This was relayed to the Multi-Agency Safeguarding Hub 2 days later. A social worker tried to call Karl's sister the next day and spoke to her on 17th April but Karl had died the day before.

2.25 Karl was found deceased by his sister in his house on 16th April 2018 and the police concluded there were no suspicious circumstances. An inquest was held and the cause of death was recorded as acute alcohol intoxication and alcohol dependency syndrome.

2.26 Case summary – Jane

2.27 Jane was a 49 year old woman who died in April 2019. Jane had multiple major health conditions including a significant injury to her spine following sustaining a back fracture in 2013. She had an extensive medical history of operations and medical interventions over many years. Her spinal condition was a cause of pain to her. She also had difficulty in swallowing. She was prescribed various medications for her conditions but she did not always remember to take these if intoxicated. Also she vomited a great deal and so would not always absorb what she did take.

2.28 Jane had a chronic alcohol dependency and epilepsy and seizures related to alcohol addiction. Some of her major physical health problems were related to her alcoholism. Historically Jane had attempted a detox from alcohol twice but unsuccessfully for reasons that are unclear.

2.29 Jane lived alone in a privately rented flat. Over the preceding years it is recorded that relationships with the family had become strained and there does not appear to be contact with her family during the latter part of her life. As such Jane's daughter nor mother have inputted into this thematic review.

2.30 From 2015 until her death Jane had had 82 attendances to the Emergency Department of the local hospital and between January 2016 and April 2019 the Paramedic Emergency Service were called out to her address on 45 occasions. There were occasions when Jane would decline help. It is also stated that she self discharged from hospital on a number of occasions though Jane denied this stating that the nurses discharged her.

2.31 Jane had some friends and a neighbour who would help her out with paying bills, cleaning the flat and general tasks. However she was highly vulnerable and had multiple seizures and falls at home. Her living conditions were poor. She had a bed downstairs with a commode as she experienced double incontinence. On a number of occasion's professionals from the ambulance service raised concerns with adult social care as to Jane's medical and physical condition and the poor state of her living conditions. Jane was also subject to financial exploitation and theft on occasions and would at times was unable to keep herself safe due to her vulnerabilities and at times would allow drinkers in to her flat.

2.32 In May 2017 Jane had surgery to her oesophagus and her nutritional status was such that she required a feeding tube to be inserted. The surgery effectively meant that she would need to have nutrition through a feeding tube.

2.33 Jane struggled to cope after this surgery and had complications requiring another feeding tube to be inserted. During this period the ambulance service endeavoured to support Jane which was good practice, but she continued to struggle personally and physically and she was debilitated. She was readmitted to hospital in December 2018 for a Sub Total Gastrectomy (partial removal of the stomach). Jane required intensive care after this procedure and after discharge she continued to have complications such as vomiting blood. She was also experiencing seizures and was unable to absorb her medication.

2.34 The ambulance service raised two safeguarding alerts as did Jane's landlord. Jane had urine burns to her legs and buttocks and was in a poor condition. Her friends also reported that they were concerned as to ongoing financial abuse. It is understood after her death that a paid carer had stolen a considerable sum from Jane's bank account over a three month period before her death.

2.35 The safeguarding concerns raised by the ambulance service during this period did result in a referral into the Multi Agency Safeguarding Hub (MASH) but this did not

result in any meaningful input by adult social services or a needs assessment under the Care Act. The reason given for this relates to the fact that Jane had numerous admissions to hospital and an assumption that the hospital social worker would deal with this. As this was already an open case, the MASH therefore treated information coming through to them for information only and the referral was passed to the hospital social worker.

2.36 In fact the hospital social worker terminated any adult social care assessment under the Care Act or otherwise in March 2019 which ultimately resulted in an absence of any consideration of the duties under the Care Act toward Jane. This included any s42 consideration. This was compounded by disjointed discharge planning between health and social care.

2.37 Jane did not recover well from the operation and had a further admission to hospital during March but it is stated she self discharged on 22nd March. It should be noted that when later questioned about self discharge Jane told a carer that she did not self discharge and was always discharged by the nurses. There is some disparity here as Jane was rather debilitated by her condition and she would not have taken discharge without help.

2.38 There is no evidence that the hospital raised any safeguarding alerts or concerns with adult social care around Jane's complex medical condition or her multiple risks. Neither was she ever considered as a frequent attender.

2.39 Jane was noted at times to be confused and therefore she may have had fluctuating mental capacity. A home visit was made on 5th April by her GP and Jane was referred to the gastroenterology team, physiotherapist and dietician. Jane declined support from the alcohol service when contacted but it is not recorded if she gave reasons for this. At this time she was receiving some support from a care agency. Some carers had possession of her bank card and access to her bank account.

2.40 On 16 April 2019 Jane was found deceased by one of the carers. There was an inquest into her death and the Coroner requested to see the community records. The cause of death needs to be clarified with the Coroner but we understand that there were no suspicious circumstances.

3 Thematic Learning Points

3.1 There are common thematic features found which feature in the lives of all three vulnerable adults reviewed. While not wishing to detract from the particular and individual circumstances of each person the review highlights that the thematic learning crosses a number of areas.

3.2 These are set out below:-

1. **The assessment and understanding of mental capacity**
2. **The efficacy of the adult safeguarding system**
3. **The significance of frequent hospital admissions - multi agency discussion in the community.**
4. **The identification and response to self neglect**
5. **Protection of adults at risk from the harm of others**
6. **Fulfilling duties under the Care Act**
7. **The provision of services for those with alcohol dependency**

3.3 These features are considered in more detail below in the context of an appraisal of practice.

3.4 The Assessment and Understanding of Mental Capacity

3.5 All three individuals were assumed to have mental capacity to make decisions and choices and generally some choices appear to have been seen more as lifestyle choices not fully understanding their context. That is not to say that those with mental capacity cannot make unwise choices but for all three individuals mental capacity was not a simple consideration.

3.6 The mental capacity of all three was complex and multifactorial but this was seen in more narrow terms at the time. Whether a person has mental capacity to make decisions is a key factor to how they will be managed by services and the law seeks to protect those who lack mental capacity as they are inherently more vulnerable.

3.7 All three individuals had alcohol dependency and it is well understood that a chronic tendency to abuse alcohol can eventually impact upon a person's cognitive functioning and memory. Some will go onto to develop Korsakoff's syndrome.[1] This was not investigated with Paul and Jane but we know that Karl had global brain atrophy. What was not further explored was the impact upon Karl's cognition

[1] Alcohol-related brain damage (ARBD) is a brain disorder caused by regularly drinking too much alcohol over several years. The term ARBD covers several different conditions including Wernicke-Korsakoff syndrome and alcoholic dementia. https://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=98

and memory. Given the above and what we know it could not be safely assumed by professionals that any of the individuals' subject to this review had mental capacity at all times particularly when intoxicated or under the duress of others.

3.8 One individual had the challenge of his home being invaded in what we now term as "cuckooing", ie, the practice of taking over the home of a vulnerable person in order to establish a base for criminal activity such as drug dealing. There is evidence of coercion in this context for Karl. Jane's story also has some inference of this but not so strongly evidenced as in Karl's experience.

3.9 The appraisal of professional practice in all three cases is that not all the factors affecting mental capacity were appreciated at the time and that the consideration of mental capacity assessments lacked formality.

3.10 The Mental Capacity Act 2005[2] protects and supports those individuals who lack mental capacity and outlines who can and should make decisions on their behalf. The Mental Capacity Act covers important decision-making relating to an individual's property, financial affairs, and health and social care. The two stage test and principles of the Act are set out below:-

3.11 The first stage is a diagnostic test:

1. Is there an impairment of, or disturbance in the functioning of the person's mind or brain?
2. Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

The second stage is a functional test. Can the individual:-

1. Understand information about the decision to be made?
2. Retain that information in their mind?
3. Use or weigh-up the information as part of the decision process?
4. Communicate their decision?

3.12 If a person lacks capacity in any of these areas, then this represents a lack of capacity (Mental Capacity Act 2005: Code of Practice).

3.13 The five principles of the Act are:-

[2] *Mental Capacity Act 2005, Code of Practice*

1. The presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2. People must be given all appropriate help before anyone concludes that they cannot make their own decisions.
3. That individuals retain the right to make what might be seen as eccentric or unwise decisions.
4. Anything done for or on behalf of people without capacity must be in their best interest.
5. Anything done for or on behalf of people without capacity should be an option that is less restrictive of their basic needs - as long as it is still in their best interests.

3.14 The Court of Protection[3] has jurisdiction over the property, financial affairs and personal welfare of people who it claims lack mental capacity to make decisions for themselves.

3.15 The High Court[4] also has powers to protect those who lack mental capacity. This is under its inherent jurisdiction. The inherent jurisdiction can be invoked for cases where an individual may on the face of it have mental capacity but whose capacity is being undermined by factors such as undue influence, duress or coercion which may prevent an individual weighing up a decision in the balance. There are various cases that outline what constitutes undue influence, duress and coercion. Where there are concerns that an individual needs to be removed from an abusive environment evidence is gathered and placed before the court with the vulnerable adult legally represented.

3.16 More complex cases where there may be multiple factors impacting upon a person's mental capacity can be more challenging for professionals to assess. In some cases, mental capacity needs to be considered formally by a senior clinician weighing up all factors that may be impairing mental capacity. In these complex cases legal advice may be required as to whether the Court of Protection or the High Court may assist.

3.17 Whether an individual has mental capacity to make decisions defines how an individual is managed in the context of their finances, health and social care needs.

[3] The **Court of Protection** in English law is a superior **court** of record created under the Mental Capacity Act 2005. It has jurisdiction over the property, financial affairs and personal welfare of people who it claims lack mental capacity to make decisions for themselves.

[4] The **High Court** is the third-highest **court** in the country. It deals with civil cases and appeals made against decisions in the lower **courts**. The **high court** is divided into three parts, which deal with different kinds of cases.

An individual who is deemed to have full mental capacity may make unwise and what may seem irrational choices but they are entitled to do so. Those who lack mental capacity are managed using best interest considerations.

3.18 However, the concept of "executive capacity" is relevant where the individual has addictive or compulsive behaviours. This is explored by Preston Shoot and Braye et al[5]. This highlights the importance of considering the individual's ability to put a decision into effect (executive capacity) in addition to their ability to make a decision (decisional capacity)[6].

3.19 It is accepted that for busy frontline professionals mental capacity assessments for more complex cases can be challenging. What was apparent at the practitioner's event was that some professionals may be more confident than others in assessing mental capacity and some appear to lack professional curiosity in this regard.

3.20 Professionals may be more confident applying a yes/no approach to mental capacity assessments but are less equipped to deal with more complex assessments or a fluctuating picture. Less awareness appears of professionals understanding how factors such as duress or coercion can affect a person's mental capacity and that further expertise and/or legal advice may need to be sought.

3.21 Therefore decisional capacity is prioritised in professional practice and the possible absence of executive capacity was not taken into account in fully determining that the individual had mental capacity. A person who may understand the need to act cannot be assumed to have the ability to act to reduce risk. Functional specific capacity assessment may mask a lack of capacity to sequence decisions in the way necessary to minimise risk.

3.22 The review team do feel the context of austerity and work pressures should not be forgotten and that professionals want to do a good job but that structurally this can be challenging. Training on executive capacity has taken place and it was felt that to undertake these more nuanced assessments of mental capacity takes time and also skills and expertise that not all professionals have acquired.

[5] SCIE report 46:*Self Neglect and Adult Safeguarding: Findings from research*

[6] *Naik 2008*

3.23 **Efficacy of the Adult Safeguarding system**

3.24 For all three individuals there were a number of concerning incidents which should have resulted in a full adult safeguarding investigation and a multi-agency strategy consideration within that framework which is mainly driven by the Care Act 2014.

3.25 The apparent lack of a coordinated safeguarding response to all three individuals hindered the fullest multi-agency consideration: information sharing; safeguarding actions and risk management. Information sharing in particular was hampered.

3.26 There are a number of examples where one agency identified the risks and sought to prompt a full safeguarding response i.e. the ambulance service for Jane but this did not come to fruition at all.

3.27 If an agency has concerns that a safeguarding matter is not being handled adequately or that repeated referrals is not triggering a meaningful safeguarding response, it is good practice to escalate this. There can at times be differing professional or agency opinions on the level of risk to an individual. An escalation process allows professionals and agencies to challenge the safeguarding team/system if a decision of no further action is considered inappropriate by the referring agency.

3.28 The safeguarding process is a framework within which services can share what they know around the individual, share risk information, assess risk and take proactive steps to safeguard an adult at risk. The information sharing element is key. The safeguarding system is now placed on a legal footing with the provisions of the Care Act 2014. This places the legal onus on local authorities to lead a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens.

3.29 The danger of an absent or superficial safeguarding response is that professionals become unclear who is leading the safeguarding process; where roles and responsibilities lie and the adult at risk is not afforded the protection they require or should be able to expect under the adult safeguarding system.

3.30 There is no doubt that agencies and professionals sought to work with the individuals involved but a high number of professionals or agencies being involved does not equate to lowered risk or a positive safeguarding system. In fact too many professionals can lead to confusion as to who is leading the safeguarding response and can at times cause a vulnerable adult to disengage or decline.

3.31 In each of the individuals reviewed they presented with multiple and accumulative risk and in each case this was not fully considered multi-agency. This was compounded by a lack of independent challenge or oversight around the safeguarding process or formal risk assessments.

3.32 One of the prominent features in all three cases was that a refusal to engage was seen in simplified terms and a reason to withdraw rather than be a risk factor in itself. This is particularly important where mental health or mental capacity could be impaired or fluctuating and where addiction is a feature. This is explored later in the report around self neglect aspect and the use of specific sections of the Care Act.

3.33 There is a great responsibility within law to protect adults at risk. The local authority are the lead agency and hold the responsibility for this working in partnership with other agencies. This includes those who self neglect. If the safeguarding system does not work effectively and all services do not know how and when to use it to good effect then there is a real danger that the most vulnerable adults in society will come to unnecessary harm.

3.34 It was also commented during the review that adult social care is very dependent upon a care management model where there is not always a distinction between qualified and non qualified staff and this model does not always meet the challenges of complex case work where individuals may present with multiple risk. Whilst there has been an attempt to move back to senior social work responses practitioners express working under increased pressures (pre pandemic) and all the findings should be seen in this context.

3.35 In May 2020, Greater Manchester Police, (GMP) published their “Adults at Risk Policy and Procedure”. This includes the new Vulnerability Assessment Framework to enable enhanced quality risk assessments and consideration to inform decision making. GMP’s Investigation and Safeguarding Model is under review and there is

work ongoing looking at a Multi-Agency Safeguarding Hub (MASH). Such changes will need formal evaluation as to whether they materially strengthen the safeguarding response.

3.36 The review team identified that multi-agency meetings need to ensure :-

1. That any police led enquiries are co-ordinated alongside any required assessment processes
2. That there is a co-ordinated referral to services not already involved, but needed.
3. That one agency leads on information sharing and ensures the adult at risk is heard.
4. That there is early coordination and consideration of mental capacity – who is best placed to assess that?
5. A whole family approach – working with families to work with agencies to support the adult at risk
6. Identifying gaps in knowledge and ascertain who will locate the information.
7. That there is a clear and comprehensive risk assessment and multi-agency management plan
8. Non engagement should be explored and assessed as a risk factor.
9. The multi-agency group should include housing so that sheltered housing or supported accommodation can be considered where necessary. In essence the strategy should include bridging any gaps between health and housing.
10. Where cuckooing is a factor there should be a strategic response, and this should be uniform across the greater Manchester area.

3.37 **Significance of frequent hospital admissions**

3.38 All three individuals had hospital admissions and two had a high level of attendance. None of the individuals came under consideration by health services as frequent attenders and there was no consideration of the reasons for high level of attendance or how to problem solve around this.

3.39 Paul's family refer to a revolving door of admissions which is a fair reflection. They also convey their concern and disappointment around the fact that on each discharge Paul was sent home to the same conditions and risks he faced before and that which resulted in him in being admitted in the first place. They acknowledge that in the safety and comfort of a hospital ward Paul may have

looked on the surface that he could manage. However objective indicators were present such as pressure sores, a history of falls and physical signs of self neglect and alcohol dependency. Further the ambulance service was reporting the dire conditions Paul was living in and yet it was deemed to be a safe discharge back to home with no safeguarding alerts being raised by the hospital.

3.40 On consideration of the frequent use of services, the review has found there is a lack of systemic rigour to identify this and yet frequent attendance must be an indicator of risk.

3.41 This does calls into question the hospitals' role in identifying multiple risk in an adult at risk and whether the hospital discharge system functions to ensure that adults at risk are seen, heard and well managed. All three individuals had serious and enduring health problems as well as alcohol dependency and disabilities and the approach to safeguarding by the hospitals appears superficial. This may in part be because of pressures upon the hospital to discharge patients in a timely manner but his is short sighted if individuals are simply attending again and again.

3.42 It should be noted that there has been an Intercollegiate document "Adult Safeguarding : Roles and Competencies for Health Staff since August 2018. [7] All health professionals are required to have at least level 1 training.

3.43 Careful preparation at the point of transition from hospital to home is needed and possible referral or completion of a Section 9 Care Act assessment made to establish is there is any change in care and support needs in the community.

3.44 It should be recognised that where an adult refuses a Section 9 assessment the Local Authority can decline to do so on referral unless, the person lacks mental capacity to refuse the assessment and the authority is satisfied carrying out the assessment would be in the adult's best interest, or the person is experiencing, or is at risk of, abuse or neglect. (Care Act 2014 – Sec 11 Refusal of Assessment)

[7] *"Adult Safeguarding : Roles and Competencies for Health Staff (August 2018)*

3.45 **The Identification and Professional Response to Self Neglect**

3.46 Self neglect is s strong feature in all three cases. Self neglect may arise from an inability, or willingness to care for oneself, or both.

3.47 Mental capacity may affect both ability and willingness. Causes of self neglect can be biological, behavioural, social or environmental and there is no overarching explanatory model. There is often a complex interplay between mental, physical, social and environmental factors. Those who self neglect may not even fully understand themselves and in cases where their cognition is impaired or where they are driven by addiction may lack insight into their self neglect.

3.48 Self neglect can polarise professional value positions, with some professionals being of the view that individuals have a right of autonomy to self neglect though self neglect may be seen in narrow, traditional terms eg hoarding, (reflecting our historic definitions). Other professionals will want to enquire and will go some lengths to build a rapport and understand the person who self neglects and fully get behind the reasons for this. It is the latter approach that supports those who self neglect.

3.49 Self neglect is a prevalent risk factor in adult social care and safeguarding. It also often exists with other risks and vulnerabilities. Since the emergence of the Care Act 2014 there is now more nuanced understanding of self neglect. The Act retained the abuse categories from the previous guidance, “No Secrets”. These are:-

- **physical abuse**, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;
- **sexual abuse,** including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting;
- **psychological abuse**, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;
- **financial or material abuse**, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
- **neglect and acts of omission**, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and

- **discriminatory abuse**, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

3.50 All three individuals' experienced a number of the above categories as well as self neglect painting a complex picture. There are a number of barriers to the professional response to self neglect such as not recognising or identifying the issue as self neglect or not recognising criteria for safeguarding or applying additional thresholds.

3.51 The formal multi-agency safeguarding system was not initiated as indicated earlier in this report and so did not capture the whole information around each individual. The appropriate needs assessments and risk assessment were not conducted. This was compounded by the fact that all three were seen as having mental capacity and making unwise, even irrational life choices.

3.52 Some services had high risk protocols which were not fully enacted. This must have been incredibly frustrating and worrying for those relatives raising concerns about their loved ones self neglecting but also exposed the individuals to unnecessary risk. A risk identification tool for self neglect would be helpful underpinned by an updated strategy and multi-agency professional guidance. There is now a Manchester Safeguarding Partnership Managing High Risk Together (MHRT), published in May 2021. There is also now a Self Neglect Strategy which was published in April 2019 so was not in place at the time of the incidents pertaining to this review.

3.53 Risk assessments should include the historical context and this assists in seeing any accumulative risk. The assessment of vulnerability should be wide ranging including health, social and environmental factors. Whether the individual has insight into their situation is key to come under consideration. Mental illness and poor cognition, for whatever reason can be a barrier to insight. Protective as well as risk factors need to be identified and families can be a rich source to understanding the individual and what may have triggered the current risks to them. In one of the cases subject to this review the family felt barriers to information sharing meant they felt at times not part of the plan to support their relative.

3.54 The literature shows that early intervention is useful in self neglect before behaviours become entrenched as well as the identification of a key professional who has the best rapport with the individual to negotiate cooperation and build trust. It is also key to obtain information and listen carefully to relatives to better understand the possible reasons for self neglect.

3.55 The interplay of the various sections of the Care Act and its intention to protect adults at risk who self neglect and are exposed to other types of abuse or risk is

an important component. Section 9 assessments could have usefully been conducted in all three cases again recognising that where an adult refuses a section 9 assessment the Local Authority can decline to do so on referral unless, the person lacks mental capacity to refuse the assessment and the authority is satisfied carrying out the assessment would be in the adult's best interest, or the person is experiencing, or is at risk of, abuse or neglect.

3.56 This brings professional curiosity to best understand the individuals' motivations for change and to deploy a proactive and coordinated approach around that person. This includes exploring fully why engagement is not forthcoming by a deeper analysis of the barriers to this for the individual in their specific circumstances. This is where outreach services are vital rather than necessarily expecting an individual who may be very challenged by addiction or other health problems, leading a somewhat chaotic life to attend at a specific place, on a specific day and at a specific time making the assumption that the individual can motivate and transport themselves to meet professionals. All three individuals were isolated but in their own way and for differing reasons.

3.57 **Protection from Harm from others**

3.58 Each community has a community safety team with community police officers who are generally sourced toward problematic areas for crime and disorder.

3.59 Professional responses to community safety are directed by legislation such as the Anti-social Behaviour, Crime and Policing Act 2014. This reforms anti-social behaviour powers and places an emphasis on putting the victim first. This statutory guidance covers a wide range of powers and is particularly focussed on early intervention.

3.60 Both Karl and Jane had problems with others coming into their property. For Karl it is clear that this was to his detriment and made him fearful and that he was subject to theft, harassment and duress. The main perpetrator as reported by him and his sister was a known female to the police. It is unclear as to the community response as this female was a problem to Karl for some time and right up to his death.

3.61 There does not appear to have been any targeted community safety work around this to protect Karl. There is evidence that Police Community Support Officers (PCSO's) had attended and that on occasions Karl thought he had been the victim of theft but he had not. On other occasions he certainly had. This should be seen in the context that Karl was in a poor clinical state and at times confused and intoxicated.

3.62 The financial exploitation experienced by Jane was initially believed to have been committed by a person in a position of Trust who was coming into her home as a carer with her consent but she also described others coming into her flat. An investigation concluded there was insufficient evidence to substantiate the carer was responsible.

3.63 It should be noted that both at times permitted other drinkers to enter their homes and then this can paint a confusing picture. However the situation concerning Karl can be fairly described as cuckooing and the review was unable to ascertain a defined strategy around this as it was not seen as this at the time by agencies.

3.64 Some cities deploy partnership strategies such as E-CINS[8] which is a 'Complete Neighbourhood Management Solution' to manage anti social behaviours and community safety for adults at risk. Intelligence shared by agencies such as the police relaying information about people of interest is key to such programmes.

3.65 Cuckooing was a factor for one individual but given the growth of this challenging area the review team explored what responses are currently in place in Manchester. Some agencies use a "Suspected Cuckooing Concerns Form" and the Community Safety Lead in the Neighbourhoods Service presents to various agencies on cuckooing and exploitation. What was less apparent is whether there is a uniform approach across the whole Manchester area.

3.66 **Fulfilling Duties Under the Care Act**

[8] www.empowering-communities.org/software/e-cins

3.67 As is indicated in this report the duties under the Care Act underpin many of the statutory duties that agencies must comply with to protect and meet the needs of adults at risk. The needs of all three individuals in this thematic review fell under the provisions of the Care Act 2014. The Care Act provides:-

> *A general duty on local authorities to promote an individual's 'wellbeing'. This means that they should always have a person's wellbeing in mind when making decisions about them or planning services*.

Wellbeing can relate to:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation
- the individual's contribution to society

3.68 Before the Care Act, individual users of services had different entitlements for different types of care and support. These were spread across a number of Acts some over 60 years old.

3.69 The Care Act replaced these and now provides:-

1. That the law focuses on the needs of individuals. The Care Act is based on the premise that the individual is always at the centre.
2. A clear framework to enable service users to better understand how the system works, and how decisions about them are made.
3. Law that is fair and more consistent, and removes anomalies that treated particular groups of people differently.
4. A clear legal framework for how local authorities and other parts of the health and social care system should protect adults at risk of abuse or neglect.

3.70 The Care Act provides a clear structure for the assessment of needs for those who may be in need of services under s9 and provision under s1 and s2. Under s 42 a local authority can also make statutory enquiries where it has reasonable

cause to suspect that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect and that as a result of those care and support needs is unable to protect him/herself against the abuse/neglect or the risk of it.

3.71 This review found that for all three individuals the duties under the Care Act were not met in varying degrees and that the Care Act response was not delivered in such a way that that the individuals concerned were entitled to expect.

3.72 It is unclear what was conveyed to each individual on the local authority's duty to them in this respect. If they did have such an explanation provided whether they could fully understand this or had mental capacity at that particular time to make supported decisions around this is not known.

3.73 **The provision of services for those with alcohol dependency**

3.74 This is included in this thematic review as a feature as all three individuals considered for this review had significant challenges with alcohol abuse. This impacted upon every aspect of their lives and harmed them physically. The medical and social impact of alcohol abuse was significant. They accessed alcohol services in differing ways and to various degrees and at times declined services of this nature.

3.75 However what was very apparent in this review was that the commissioning of these services is inconsistent. Those from this field explained that sometimes a good rapport and progression is achieved with an individual but then the provider is changed as part of a reviewed procurement exercise and this can destabilise established work.

3.76 What was also conveyed is that the incidence of alcohol dependency and associated problems in increasing and so the resource of this type of service is very stretched.

3.77 It is not uncommon for alcohol dependency to co exist with mental illness and so a dual diagnosis care pathway is needed at times. This means that alcohol support services must be joined up with mental health services.

3.78 There are also sound national strategies such as Alcohol Concern's Blue Light Project [9] These identify the real importance of outreach services into the community. The team working with Karl was working with a change model but had not the opportunity to work with him intensively before he died.

3.79 The provision and strategy around alcohol services merits a formal audit as this factor of risk alone can make an individual high risk and very vulnerable for obvious reasons.

4 Summary of Findings

Findings
FINDING 1 **Further development work is required across all agencies as to when and how to assess more complex considerations of mental capacity**
FINDING 2 **There are apparent challenges to the adult safeguarding system which mean that a full multi - agency response is limited.**
FINDING 3 **Currently there is no uniform or formal method to assess risk around, or manage frequent hospital attendance**
FINDING 4 **The concept and management of self neglect requires further development building upon the current policy formulation published to date**

[9] *Working with Change Resistant Drinkers The Project Manual – Mike Ward and Mark Holmes 2014*

Findings
FINDING 5 **The protection of adults at risk from the harm of others requires joining up across the cuckooing strategy to the wider community safety plans**
FINDING 6 **Care Act compliance should be reviewed across the Partnership**
FINDING 7 **The provision of services for those with alcohol dependency needs to be commissioned in such a way as to provide service users with continuity and flexibility, and be part of a dual care pathway if required with a strong outreach ethos.**

APPENDIX 1

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