



Sheffield
Adult
Safeguarding
Partnership

SAFEGUARDING ADULT REVIEW REPORT

“Person E”

December 2021

Contents

Section	Description	Page
1.	<u>Introduction</u>	3
2.	<u>Summary of the Case, Key Practice Episodes, Appraisal and Learning</u>	8
3.	<u>Review Terms of Reference, Findings and Recommendations</u>	26
4.	<u>Appendices</u>	37

1.Introduction

1.1 This report covers the findings and recommendations of the Safeguarding Adult Review, undertaken on behalf of the Sheffield Adult Safeguarding Partnership (SASP), relating to the death of an adult in 2019 (referred to as E throughout this report to preserve his anonymity).

1.2. The Safeguarding Adult Review (SAR) is not intended to attribute blame, but to learn lessons from this case and make recommendations for change that will help to improve the future safeguarding and wellbeing of adults at risk in Sheffield in the future.

1.3. The review was conducted in the light of the following legislation: Section 44, Care Act 2014 Safeguarding Adult Reviews¹.

The purpose of a Safeguarding Adult Review is described very clearly in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'.

The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

The Department of Health Care and Support Statutory Guidance – published to support the operation of the Care Act 2014, states¹:

14.163 Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

14.168 SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

1.4 Why was this case reviewed?

Initially the case was raised with the SASP as a potential case for review in July 2019 by the South Yorkshire Police Case Review & Policy Officer, following the discovery of E's body in his home after Police had been called by a concerned neighbour. Due to the length of time E had been deceased his cause & date of death was uncertain, but police identified issues of self-neglect both in their prior contacts with E and current self-neglect of his partner F. Police also had some information about E's mental and physical health problems, along with a previous history of domestic abuse to his partner, F. As the SASP subgroup dealing with SARs felt there was potential learning for the agencies involved in, the case was accepted as an appropriate

¹ <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1>

referral in September 2019 and a SAR was commissioned in March 2020, and an independent reviewer appointed following a formal tender process.

1.41 Brief Summary of the Case

E was a 41 year old white man, at the time of his death being discovered and he had lived in a rented house with his partner F. They were not married, but had been in a relationship for 22 years, according to reports made by F to the police. There is little early social history available on either E or F prior to the contact F had with the police in 2017, at which point she alleged a history of increasingly serious domestic abuse from E for most of the past year. She also reported a deterioration in E's mental state, with increasing social isolation and self-neglect. He had stopped leaving the house altogether by February 2017 and he also prevented F leaving the house for some weeks, through violence and coercive control. He then permitted her to return to her job, in the care sector, but the domestic abuse continued.

By June 2017 E had stopped attending to his personal care, was very dirty with a long unkempt beard, was electively mute, communicating only through gestures and he also prevented F from keeping the house clean or tidy. The violence increased to F through the subsequent months, which she reported to police along with her concerns for E's mental state, as by this time he had become largely bedbound and was threatening suicide. Following a welfare visit by police E was arrested and after being checked for any physical illness at hospital, he was charged, then bailed for common assault on F. He was subsequently admitted to psychiatric hospital for assessment in October 2017 under Section 2 MHA '83² and after a brief period of stepdown care he was then free to return home, as his Section had expired and the criminal charges against him were dropped. He declined follow up from mental health services, who closed his case due to non-engagement. He was not seen by any services again, until the neighbour reports led to the discovery of his body in July 2019, where it appeared he had been deceased at home for months.

1.5 Timeframe, Terms of Reference, Methodology and Scope

This review covers key periods of contact between August 2017 and July 2019 for the case up to the events immediately prior to the discovery of the death of E.

The methodology for this SAR was through a collation of Individual Agency Documents and Chronologies submitted by relevant agencies working with both E and F. The SASP then collated a combined merged chronology from all the individual agency submissions. The combined chronology was then broken down to several distinct phases of contact called Key Practice Episodes (KPE)³. The involvement of services during each KPE was then appraised and underlying factors affecting decisions and actions were then explored to explain the practice in this case and potential wider implications. In order to explore some additional factors and context to the work in the case a series of clarification questions were addressed to the key agencies.

² <https://www.legislation.gov.uk/ukpga/1983/20/section/2>

³ <https://www.scie.org.uk/publications/guides/guide24/concepts/episodes.asp>

1.6 Agencies that had involvement in the case:

- South Yorkshire Police
- Sheffield Teaching Hospitals
- Sheffield CCG (GP)
- Sheffield Health and Social Care Trust
- DACT (Domestic Abuse Coordination Team/IDVA's (Independent Domestic Violence Advocates)

1.7 Methodological comment and limitations

It was a significant challenge that the review was unable to involve F and that little was known about the relationships and social history of either E or F. As seen in section 1.4.1 there was limited information available from the agencies involved with the case and where agencies were involved this was generally brief. Further limitations were caused by the circumstances of the nationwide lockdown in 2020, which led to delays and subsequent impact on all services involved with this case. Meetings were held online for the review and conversations were not held with the professionals that had been involved with the case, due to staff turnover and the limited direct contact services had with him.

1.8 Parallel Processes

Prior to the SAR being commissioned there was a criminal investigation, which was instigated shortly after E's death became known, and charges were considered against F, in relation to preventing the Coroner in the exercise of his duty, by not reporting E's death. This resulted in her not being consulted as part of the SAR process whilst this process remained ongoing. This was progressed to the CPS who stated that, whilst the evidential criteria were met, they did not believe it was in the public interest to pursue the matter through the courts. Due to the badly decomposed state of E's body upon discovery, the cause of death was undetermined although several old injuries and fractures were found during the detailed autopsy report in July 2019 which will be summarised in more detail during the next section of the report.

This was confirmed at an Inquest held by Sheffield Coroner's Court in January '21, at which the outcome was a narrative outcome, as follows;

"E was pronounced deceased on 5 July 2019 at his home address, his medical cause of death remains unascertained. Given the time period between the likely date of death (January 2019) and the discovery of the body, the court is unable to confirm how E came by his death."

1.9 Reviewing expertise and independence

An Independent Lead Reviewer (Mick Haggart) was appointed by the SASP to undertake this review. He confirmed no prior employment with any agency in Sheffield and a substantial history in Safeguarding Work, including experience of reviewing over 20 other cases, either as a SAR, or as a Serious Case Review. All relevant documentation was then shared with and scrutinised by the Independent Lead Reviewer, to compile this Overview Report.

1.10 Acronyms used and terminology explained

Appendix 1 provides a list of any abbreviations used to support readers who are not familiar with these terms. In Appendix 2 language and terminology of medical and safeguarding work is explained and referenced. References are also made to key guidance or research in footnotes throughout the report.

1.11 Involvement of family members

The input and opinions of family members of the deceased is an important aspect of the SAR process, both to inform them of the review, and to include them to take account of their first-hand experience of services provided to them/their relative. The partner of E (who is referred to as F throughout the report) was contacted by letter to notify her of the SAR and invite her participation in June 2020, but following no response further enquiries revealed that she had moved to a different Housing Association property. Follow up via her Housing Support worker in August revealed that she was doing well since her move and the letter was then hand delivered by this worker to her new address, but again no response was received to date. This was further followed up with F in 2021, but she did not reply to requests from SASP to make contact and appeared not to want to be involved in the SAR process.

1.12 Role of the SAR Panel

As the accountable body responsible for commissioning this SAR, the Sheffield Adult Safeguarding Partnership (SASP) SAR Subgroup appointed a SAR Panel to oversee the SAR and receive updates on progress at meetings. The SAR panel of statutory partners were tasked to oversee, manage and scrutinise the work in relation to the SAR, ensuring it remained on schedule, managed any areas of difficulty that arose, and ensured the quality of the report produced in line with requirements. A first panel meeting was due to be convened in April 2020, but was postponed until May, due to the Pandemic. Reports and chronologies were requested from agencies with further meetings to refine the Terms of Reference and monitor the progress of the Review were then arranged in June, when individual chronologies were merged into a combined chronology. Further reports were received from agencies in September, October and December 2020. This Report was drafted for consideration and approval initially by the Panel and SAR Sub-Group prior to endorsement by the overall SASP.

1.13 Terms of Reference/Specific Areas of Enquiry

The SAR (and by extension all contributors) will consider and reflect on the following:

1. Evaluate the appropriateness and coordination of multi-agency interaction, communication and support provided to Adult E.
2. Identify any missed opportunities for agencies to intervene and affect a positive outcome during the timeframe for the review. (including after the submission of 2 safeguarding concerns and the referral to MARAC).
3. Assess the effectiveness of the actions agreed at MARAC (or VARMM) in keeping the people in this case safe.
4. Recommend any additional follow up processes that should be in place where adults are not in touch or in contact with services.
5. Evaluate the support provided by the IDVAS.
6. To identify learning in multi-agency work with people who self-neglect, including risk assessments and proportionate professional intervention.
7. To identify learning in how professionals work with people who refuse to engage with them and who persist in risky behaviours. (discharge / alcohol)
8. Consider multi agency responses to someone who repeatedly misses appointments (including after periods of inpatient care for mental health illnesses).
9. Evaluate evidence submitted for significant changes in circumstances (between September and October 2017) that triggered the repeat hospital admissions?
10. Review practice in this case regarding GP annual reviews and the support might these have provided

Adult E had a range of complex needs including alcohol misuse, poor physical and mental health, perpetrated domestic abuse and coercive control. Evaluate the response to these challenges by agencies involved in this case.

2. Summary of the Case, Key Practice Episodes, Appraisal and Learning

The section summarises the multi-agency chronology of involvement in the case. The SASP Administrator collated this chronology from the individual agency chronologies and other reports. As outlined above, the integrated chronology for the case was then divided into six Key Practice Episodes (KPEs), which are set out separately, along with the significance for practice during each KPE. These are then analysed further for potential wider learning.

2.1. Key Practice Episode 1 (31/08/17 - 05/09/17)

During this time F made several calls to the police about Domestic Abuse (DA) from E, this included physical violence (punching, kicking & slapping her), locking her in the house and threats/coercive control. F also makes a call to 111 (NHS number for non-emergencies) seeking help for E due to his self-neglect, she was worried he had had a breakdown and was at risk of suicide. A copy of the notes from this call was sent to the GP.

F was referred to Action (local domestic abuse service) by the police, who then made contact with her, although she was at work, as a carer. Officers attended the joint property of F & E, to conduct a welfare check. The call was graded as priority, after initially knocking and getting no answer officers obtained entry to the address by a key provided by F. On entering the property, they were overwhelmed by the smell, as there were 10 to 20 cats roaming freely around the property. Officers noted rubbish and faeces on the floor and numerous empty bottles of alcohol strewn around each room.

The officers went upstairs where they found E in a bedroom, initially mistaking him for being deceased as he was laid on his back in the prone position. E did not move or respond to officers calling his name, staring at the ceiling and refused to respond to anything that was being said or being asked of him. They noticed that he was very emaciated, had terrible conjunctivitis in both eyes and that his hair and beard were matted. Officers arrested E for the offences disclosed by F at this point he stated, "I have not done anything". E was struggling to walk which suggested to them that he had perhaps been laid in bed for some time. They transported E to Accident and Emergency (A&E) at the Northern General Hospital (NGH) and after general observations he was discharged 5 hours later back into Police custody.

A letter was copied to the GP of this assessment, which identified his condition as "a social problem" although he was noted to be unwell, but no details of with what condition. The plan was for follow up by the GP, but again no details of what this was thought to be. E also did not speak during his time at the Emergency Dept and a safeguarding referral regarding the identified concerns over self-neglect was raised by A&E staff which was sent to Sheffield Adult Social Care, Safeguarding Team. This was forwarded onto the Mental Health Team, at Northlands, although at this time he was not open to any mental health service and there was no response to this referral.

He was then taken to custody but remained uncommunicative, was charged with 3 counts of common assault and bailed, on condition that he could not to return to his

home, or have any contact with F. He was seen in custody by a police liaison mental health worker, who contacted his GP to see whether there was a known history of mental health problems, although none was known by the GP at this stage.

Police then referred the couple to both MARAC (Multi Agency Risk Assessment Committee) and completed a CID 70 (Police referral form) to refer him once more to Sheffield Adult Social Care, Safeguarding Team, due to the concerns about his mental health and self-neglect. This CID 70 was then sent on to CMHT (Community Mental Health Team) at Northlands by Adult Social Care Access Service, as above. Action were called by Adult Social Care, to report he was known to Mental Health Services, although a review of records subsequently confirmed that this was not the case.

F was spoken to briefly by the DA service, at which point she was at work but had also left the property to stay with friends, so this gave a window of opportunity to engage with her about her safety.

2.1.1. Significance

As the first period of contact with services this gave an opportunity to intervene with E both as a perpetrator of DA and as an adult showing serious signs of self-neglect with a very poor state of physical health and home environment. Police first attendance at his address was in response to F's concerns about E and he was arrested due to the DA allegations. He was initially taken to A&E due to his poor health but did not have any treatment in the hospital prior to being released back to the police for an interview.

At this point the health staff raised a safeguarding concern to Adult Social Care Safeguarding Adults Services, which was then sent onto mental health services, despite subsequent confirmation of him not being known to them. There is no information on any follow up by any services to this safeguarding concern, which did not result in any action under safeguarding procedures at this point, which appears to be a missed opportunity (although it was picked up in the next KPE).

2.1.2. Appraisal Of Practice

The calls made by F to police were appropriately responded to by an initial home visit by officers, who then arrested him in connection with the allegations of DA. It was good practice to get his health checked out in hospital, due to his very poor physical appearance at this time. However, the response in hospital was not to admit him and he was discharged the same day to police custody, with follow up requested to his GP. This appears to be a gap in practice, as both his poor physical & mental state warranted further medical assessment at this time, but he was not admitted and his need for follow up via his GP seemed unclear as to what this was, or what it was expected to achieve.

The follow up from DA service was good initially in making contact with F, although she did not engage with this - the reason for this is unclear, but it may have been as a consequence of the coercive control E had subjected her to. This was an example of the frequent difficulties experienced by women in accessing support when subject to Domestic Abuse. Further multi agency work could have been initiated by the Safeguarding Concerns raised during this period when he was first taken to hospital

(one by Hospital staff and one by the police via CID 70). However, it appeared that these were sent onto Mental Health Services, without any triage or further follow up from Adult Social Care.

From the information received, this appeared to be in the mistaken belief he was known to Mental Health Services. Interestingly, the Mental Health Liaison worker at the Police Custody suit contacted his GP to check on any known mental health history at this stage, but none was known. There was no record as to whether either of these 2 Safeguarding Referrals led to any action under Safeguarding, or Self-Neglect procedures, which is a gap in practice and a missed opportunity to instigate multi agency action. Neither referral was followed up (by either hospital or police referrers) to check on whether any action was taken in response to these.

2.1.3. Summary Of Learning

- **The assessment of E at the Emergency Department did not identify any medical need for admission for treatment, despite him being electively mute and severely self-neglected.**
- **The assessment of E at the Police Station led to appropriate referrals to MARAC, due to the high risk of DA, and to Adult Social Care for his severe self-neglect, in line with Police Procedures.**
- **Whilst in Police Custody a Liaison Mental Health Worker checked whether E had a history of known mental health problems with his GP, but none were recorded.**
- **When he was charged and bailed at the police station, he had bail conditions not to return home, but no work was done to identify any other address that he could return to, which led to E sleeping rough.**
- **Both Safeguarding Referrals sent to Adult Social Care, were sent straight onto Mental Health Services inappropriately, without sufficient work to clarify whether he was currently known, or allocated to a worker.**
- **Neither referral led to any action under Safeguarding Procedures by the Mental Health Trust, which was not followed up by any of the agencies involved in raising the referrals (Police, NHS, Adult Social Care).**

2.2. Key Practice Episode 2 (05/09/17-13/09/17)

After being released on bail by the police (as set out above on 03/09/17)E was found in the street, after a member of the public called an ambulance. He told the ambulance crew that he had slept outside since being arrested 2 days earlier. He was described as peripherally very cold and cyanosed (bluish tinge to the skin) with wet clothes and matted hair. He was taken to the ED (Emergency Department) as a place of safety.

He was found to have severe skin damage secondary to ammonia burns from urine and faeces and required a full head to toe bed bath. He was described as emaciated and malnourished. He was clearly at significant risk and so was appropriately returned to hospital for further assessment. This was made known to Adult Services by a telephone call from ED, who then also updated the DA service about this admission. While in hospital his fractured arm was reviewed by Orthopaedic services, who held a trauma

conference about this injury, which had occurred at some time previously but he hadn't had any medical care at the time, so it had re-set incorrectly.

On the same day DA services attempted to contact F again, but without success, they didn't leave a message in case E was at the property (although he was in hospital at this time, which Adult Services had previously informed them about).

He was in hospital for a week (from 05/09-12/09). His cooperation with his care was variable and he would often refuse to have blood tests and other interventions. There was no assessment of capacity during this hospital admission. A Mini Mental State Examination was undertaken on which scored 28/30, therefore it appeared that he was assumed to have capacity. He could be agitated and aggressive at times and required sedation to calm him down. On a couple of occasions security were called to try to persuade E not to leave the ward.

A number of possible diagnoses were mentioned/explored during this time (Urosepsis was suspected [blood infection emanating from Urinary Tract infection⁴] renal failure and acute kidney injury, but there was no confirmed diagnosis recorded. F contacted the ward to share her concerns about his deterioration, she also alluded to some Domestic Abuse and wanted to drop off clothes for him; she was reassured she did not have to see him at this time.

He was treated for the symptoms of alcohol withdrawal - possible Wernicke encephalopathy (brain damage caused by a lack of vitamin B1, common in people who have alcohol use disorder⁵). He was given IV medication via a reducing regime of Chlordiazepoxide⁶ for alcohol withdrawal. His mental state had improved, he was more alert and communicative, sitting up and engaging with nurses and treatment.

During his admission he was not seen by psychiatric services, who remained in contact with ward staff and agreed to wait till his detox medication treatment was completed prior to an assessment. They then attempted to visit on the 12/09 but he had discharged himself against medical advice, so he was not seen. Due to concerns the Social Worker from the Mental Health Liaison Team raised this with both the Police and Safeguarding Team. Action (the DA agency) made more attempts to contact F directly and via her friends, without success. The day after he left hospital he was once more arrested by the police and taken into custody, having breached previous bail conditions by returning to his address with F, saying he was going to kill himself. F also contacted the police who attended the house. E still refused to speak but was deemed to be fit to be interviewed when assessed by a Mental Health nurse, albeit through the hatch of his cell door. He refused offers of a shower.

Communication between Action and the nurse confirmed E was not previously known to any mental health services. E again refused to engage with anyone, declined interview and did not offer any defence, mitigation or alibi. CPS advice was sought as he was facing three charges of common assault on F. He was remanded by the Custody Sergeant and appeared at Sheffield Magistrates Court the following day, where he was assessed by Liaison Services, where he denied any symptoms of mental illness. He

⁴ <https://www.sepsis.org/sepsisand/urinary-tract-infections/>

⁵ <https://bestpractice.bmj.com/topics/en-gb/405>

⁶ <https://bnf.nice.org.uk/drug/chlordiazepoxide-hydrochloride.html>

was again bailed by the Court with the extra bail condition that he was to live and reside at a specified address in Hull, which was accommodation known as a BASS (Bail and Accommodation Support Service) run by NACRO (National Association for Care and Rehabilitation of Offenders), although he faced no extra charge for his previous breach of bail. He was released from custody after the last train had left for Hull, so it was not clear how he was expected to reach this accommodation. He did not arrive at this bail address and was re-admitted to hospital the next day (see KPE3, below).

The following day Adult Services records indicated that he was signposted and his case closed, although signposted where and for what is not recorded, presumably this was to Mental Health Services, despite the fact that at this stage he was still not known to them and no records of any action were noted in response to this from Mental Health. A review of one of the Safeguarding referrals showed this was closed as not meeting the threshold for any further action, due to him being in hospital at the time - this appeared to be an inappropriate decision, as the concerns related to his chronic self-neglect and the DA when at home, so his admission was unlikely to address these.

2.2.1. Significance

During this period of the chronology E was found in a public place, having been doubly incontinent and in need of urgent health care, following his release on bail 2 days earlier by the police. It appeared he had been sleeping rough as he was found shivering on a bench at 6 am on the day of his re-admission. Clearly, he was not able to cope and this indicated some cognitive difficulty, possibly due to his alcohol dependence and/or untreated mental health problem. Tests were undertaken during his stay in hospital, to explore any organic cause of his difficulties. Blood tests confirmed an Acute Kidney Injury and possible urosepsis (urinary tract infection). He was prescribed intravenous fluids and intravenous antibiotics. E was also showing signs of alcohol withdrawal and became agitated at times. He was prescribed Chlordiazepoxide which is a medication given to control Delirium Tremens. E also had an x-ray of his arm which showed an old fracture to his humerus

An opportunity to assess his mental health was missed during this admission. Evidence of severe self-neglect was again apparent but it is not clear what the underlying physical or mental health causes of this were thought to be, partly due to E's non-compliance with blood tests and medical offers of care, although he had improved while in hospital. Whilst he was in hospital DA services tried to speak to F but without success, it appeared she was still going to work and staying with friends. E contacted her again when he left hospital, he returned to the flat and was re-arrested for this but was still refusing to cooperate with offers of help or to speak to police, whilst in custody.

2.2.2. Appraisal Of Practice

The lack of alternative housing for E meant that in order to comply with his bail conditions of not returning home he slept rough for 2 days, which indicates the difficulties experienced when suspects are bailed without an alternative home address and highlights a challenge for police to balance the risks of DA with the needs of

alleged perpetrators. He clearly was not able to manage without care, having been found suffering from the cold, malnourishment and double incontinence. On his second assessment at hospital he was then admitted for urgent health care and assessment, which was appropriate. However, he refused to comply with the medical assessment, which meant that the cause of his difficulties, whilst suspected to be from a UTI &/or from his alcohol consumption, were not clarified.

He remained mainly mute during this admission and non-compliant with health care, despite this he was deemed to have capacity and although attempts were made to dissuade him from leaving he was not prevented from discharging himself. This appears a gap in practice, as he was both vulnerable in his own right and posed a risk to F, should he return home in breach of his bail conditions (which he subsequently did). He could have been prevented from leaving hospital, lawfully if a DoLS (Deprivation of Liberty Safeguards⁷) request was done but this was not pursued at this stage. Also, it is unclear why during the admission he had been referred to, but not seen by the Psychiatric Liaison Service for an assessment of his mental state, until he had self-discharged, which was another missed opportunity to clarify the nature of his difficulties.

Police were once more contacted by F, as after E left hospital he returned to the flat, potentially putting her at risk of further abuse. He had no alternative address, but was again appropriately arrested for breach of his bail conditions. He was then reassessed by Mental Health Liaison Nurse and a Doctor who deemed him capacitated and fit to be interviewed which appears surprising as he was again mute when police tried to interview him. He had made threats to kill himself to F prior to being re-arrested, but no referral was made by the police, liaison nurse, or doctor for a formal Mental Health Assessment, which was a further gap in practice. Following attending Magistrates Court he was once more bailed but with a variation to include an address (a bail hostel run by NACRO) in Hull, but it was not clear how he was going to get there. As he had no support from any service at this time, due to his referrals to Adult Social Care that had been closed and he was not open to any Mental Health Team, he was once more made effectively street homeless when he left Court where he slept rough before coming to the attention of emergency services (see KPE 3).

2.2.3. Summary Of Learning

- **The impact of a brief period of sleeping rough exposed the lack of any alternative housing, or community support available to E**
- **His second the attendance at Emergency Dept led to admission, but it is unclear whether his presentation was any worse than first attendance.**
- **His medical condition was poor, with double incontinence, possible infection (UTI) and suspected cognitive impairment, but despite his non-compliance with care he was not prevented from discharging himself.**
- **His self-discharge put his own health at risk and potentially posed a risk to F of further violence.**
- **His subsequent re-arrest and assessment in custody did not identify any concerns over his current mental state despite his self-neglect and threats of**

⁷ <https://www.sheffieldccg.nhs.uk/Your-Health/deprivation-of-liberty-safeguards.htm>

suicide, leading to him being released rather than assessed under the Mental Health Act, whilst in the custody suit.

- His bail conditions were varied to specify an address in Hull at a specialist bail accommodation service, but without the necessary support to travel there he was unable/unwilling to attend at this service.
- He was assessed while at Court by Liaison Psychiatry but denied any symptoms of mental ill-health, so was bailed, with the conditions as set out above.

2.3. Key Practice Episode 3 (14/09/17-24/10/17)

Following his self-discharge from hospital, E was found once more by emergency services in a public place, sitting shivering all night on a bench (from 22.00-05.30). He could not recall how he got there, was still not speaking and refusing care by the ambulance crew. He was then readmitted to hospital and did not recall the circumstances of his previous admission when spoken to by a nurse at 06:20 and could not remember being in an ambulance. A letter was sent to his GP about this admission, which identified suspected macrocytic anaemia⁸ (often linked to alcohol excess and liver dysfunction]. Although E was not known to be diabetic, insulin treatment was needed to treat his high blood sugar levels.

Notes indicate that E was experiencing delirium due to alcohol withdrawal and had been prescribed a detoxification regime at the Medical Assessment Unit (MAU) at the Northern General Hospital (part of STHFT). E's mental health was subsequently discussed with the Mental Health Liaison Team (MHLT) and his mental capacity was considered. It was agreed to act in the best interest of E in order to investigate and treat him and to rule out organic causes for mental ill health. There was no record of a formal MCA assessment.

There is an entry in the medical records regarding a telephone conversation with liaison psychiatry - E was not cooperating with any assessments or investigations or treatments and refusing to communicate, his eyes were closed and he remained mute. Therefore it was deemed that he was unlikely to have capacity or to be able to communicate any decisions. Liaison psychiatry advised that E could be treated, and investigations undertaken in his best interest. Should E wish to leave the ward he would need a DoLS. A DoLS (Deprivation of Liberty Safeguards) request was then made to authorise his detention in hospital in his best interests.

There is little documentation regarding any specific investigations or treatments during this period. Routine blood tests were undertaken and he had a chest x-ray on 15/09/17 which was clear. He was declared medically fit for discharge on the 17/09/17 and a mental health assessment was requested on the 19/09/17. The reasoning for this was that he was refusing to engage. He was described as "lying down with his eyes shut" and "remained mute" when staff attempted to converse with him. His Doctor queried whether he had Catatonia, (a neuropsychiatric behavioural syndrome that is characterised by abnormal movements, immobility, abnormal behaviours, and withdrawal. The onset of Catatonia can be acute or subtle and symptoms can wax, wane, or change during episodes.)

⁸ <https://www.healthline.com/health/macrocytic-anemia>

He was reviewed by a Consultant Psychiatrist on the 19/09/17, at which he was unresponsive and detained under Section 2 MHA '83, after which he was discharged from Sheffield Teaching Hospitals NHS Trust (STHFT) and transferred to Stanage Ward in Nether Edge Hospital (an acute mental health inpatient ward, managed by Sheffield Health and Social Care Trust). A number of diagnoses were suggested when he was admitted to this ward – schizophrenia, alcohol issues, delirium (which could have been attributed to severity of his infections). However, there was no clear mental health diagnosis made or recorded. Whilst on the ward, E was also referred to the Recovery Community Mental Health Team.

A safeguarding concern was raised by Stanage Ward staff about STHFT due to blood and faecal matter in his pyjamas. He resisted attempts to examine this, also his shoulder injury and foul-smelling, weeping sores which were causing him considerable pain and had not been treated by STHFT prior to this transfer to Stanage Ward. He was seen and then transferred back to STHFT later the same day, where he was seen in the ED by a doctor. Oral antibiotics were prescribed for his infected abscesses, which had burst; a discharge summary/plan was for these to be re-assessed was sent to the GP for follow up in 2 week's time. No treatment was needed for his shoulder injury. It was not clear what (if any) action was taken regarding the safeguarding referral about his transfer to a psychiatric ward before these conditions were treated. No records of this referral were found upon review by STHFT.

By coincidence, his case was also discussed at MARAC on the same day (19/09/17), the IDVAs had not been able to speak to F again and were planning to close the case if there was not further contact. A case note recorded by the IDVA (22/09/17) stated they were to contact Probation to ascertain where E is living and his plans for return. If there was no contact by the next week, they were to close the case as F was not engaging and there were no other routes of contact identified from MARAC. The IDVA service then closed F's case, as further contact was attempted with her, but not responded to. This was recorded in MARAC minutes (19/09/17) where the case was discussed. It appeared the IDVA service were unaware that E had been detained under the MHA '83. Despite the obvious issue of alcohol dependency, from both the 50+ empty cider bottles and inpatient detox, no mention or referral was made to alcohol services at this meeting.

Whilst on Stanage ward E was initially still mute and responsive to assessment, for the first week of his admission. He refused to take antibiotics, remained in his room and pretended to be asleep when seen by staff. He first got up on 26/09/17 and was seen briefly around the ward. His partner made several calls to the ward to speak to him, but due to bail restricting any direct or indirect contact this was not allowed by staff. He would occasionally accept staff prompts to shower, to take his antibiotics, as well as to eat and drink when this was brought to his room but not while staff were present. Most inpatient records note that he was mute and avoiding all contact even eye contact with staff.

He was spoken to about an Environmental Health assessment of his property but refused to acknowledge or engage with this, remaining mute and thought to still lack capacity on 26/09/17. This pattern continued of minimal engagement, nodding or shaking his head in response to questions and remaining in/on his bed all the time.

He did comply with blood and urine tests, which showed no issues other than his renal impairment. He had cream prescribed for his skin infection and boils.

On the 03/10/17 ward staff managed to contact his partner, updated her about his condition and requested a meeting to gather further background information to assist with diagnosis and treatment plan. She refused the offer of Environmental Health assessment and said the property was fine now as she was back living there. At an MDT meeting later that day E was thought to be psychotic and Olanzapine was prescribed for him. It was noted he was still mute. This pattern continued during the next week of his admission, with his compliance with prompts to shower, while staff changed his bedding which was often blood stained from his abscesses. He spent all the rest of his time in bed and was still mute when questioned. He was given pen and paper but did not use this either.

On 09/10/17, E's solicitor requested for bail variation after being contacted by a mental health practitioner from Stanage Ward at the hospital E had been sectioned to, the day after his appearance at SMC on the 13/09/17. This request was to allow F to visit E at the ward as he had still not spoken to anyone whilst in hospital. The OIC made contact with F to ascertain her view on the request and she was reported to be in agreement with this alteration in the circumstances. Considering that F would be protected whilst on the ward, the OIC deemed it acceptable to lift the condition. E's bail variation was changed on 10/10/17 to read '*Exclusion: not to contact directly or indirectly F save through medical professionals for the purposes of his assessment*'

When seen by a ward doctor on 11/10/17 he was told his Section was due to expire and he was recommended for a further period of treatment in hospital under S3 MHA, with his doctor completing a Medical recommendation for S3 - he still refused to engage at all when assessed.

On 13/10/17 he requested his partner bring some clothes to the ward, he also used the paper to request cigarettes and answered a few questions verbally for the first time, although he had no insight into his condition or why he had been mute for almost 3 weeks on the ward. It was speculated that his improvement may be due to the Olanzapine medication and the following day he spent a little time outside, appearing amazed that he had been on the ward for 3 weeks. On the 14/10/17 his partner contacted the ward, wanting to see him and bring clothes, but when told she was still not allowed to have direct visits she refused to come to the ward with his clothes. He was due to be further assessed by an AMHP (Approved Mental Health Professional) for further detention for treatment under S3 MHA on 15/10/17, but this was postponed due to his recent change in presentation and when re-assessed the next day by an AMHP and doctor. He denied any problems, stating he had been mute as he was nervous of others. He did agree to medication and follow up in the community so he was not detained under S3. The Section 2 lapsed and he was regraded to be an informal patient on 17/10/2017.

The following day E was admitted to a step-down bed at Wainwright Crescent (the bail conditions prevented him from returning home). (Wainwright Crescent is a 12-bed residential step-down provision for service users discharged from the Trust's

inpatient wards⁹) He was referred to the Home Treatment Team for follow up after discharge, which he apparently accepted. Whilst at Wainwright Crescent E was visited by staff from the Home Treatment Team and reported feeling well and did not understand why he had been admitted to hospital. He did not report feeling depressed and denied any self-neglect. E had contact with F during this time through a phone call.

On 23/10/17, F called 101 stating that she wished to drop all charges against E and that she was due in SMC (Sheffield Magistrates Court) the following day so the matter was urgent. An email was sent by Atlas court to the file preparation unit who then tasked the OIC (Officer in Charge) for an officer to attend the property and attain a retraction statement from F. There was no answer to this visit and a contact card was left requesting that F contact SYP as a matter of urgency. No further contact was received from F.

The case was heard at SMC on 24/10/17, and no retraction statement had been gained. All attempts to contact F were passed to the court. The case was then finalised by the court as 'No case to answer' due to F failing to appear to give evidence on the day for the prosecution. E attended the Magistrates Court, but as the case was dropped, he then returned to Wainwright Court and requested he be discharged. He then left the stepdown unit as he was no longer subject to bail conditions and presumably returned to reside with F in the seriously neglected home environment. He was discharged with a 7-day prescription for Olanzapine and antibiotics. Staff also communicated this to the Home Treatment Team as well as their concerns that E may not continue to take his medication.

2.3.1. Significance

Once more when he was released on bail E had nowhere to return to (other than the address in Hull) and was found again in the street, having spent the night on a bench. It was known by the police that he had been sleeping rough previously but this was not followed up to ensure he had someone safe to return to. His re-attendance at hospital did this time lead to admission, but the events could have been avoided if he had been admitted the first time he was taken to hospital.

It is unclear whether he was in a worse physical state on this occasion, or there was another non-clinical reason for his admission for assessment. Furthermore, it is unclear whether his mental state had deteriorated but on this admission an application for detention in hospital under DoLS was made, indicating that a doctor now thought he lacked capacity to consent to stay in hospital. This would have given a lawful basis to keep him in hospital until the suspected physical/organic causes for his presentation were clarified, as per the plan. The DoLS request was for an urgent authorisation, which allowed the hospital to detain and treat him.

The reasons for this as set out on the request form were as follows;

⁹ <https://www.shsc.nhs.uk/services/wainwright-crescent>

“He has an acute kidney injury and hyperkalaemia¹⁰, both of which require medical treatment with hospital.

He has alcohol excess and is experiencing symptoms of detoxing.

He lacks capacity and is currently refusing all medical treatment.

He is refusing observations, bloods and Iv treatment.

E is at risk from death the hyperkalaemia and acute kidney injury are not treated”.

However, the DoLS assessment was not completed as 4 days later he was detained under the Mental Health Act '83 instead. It is always difficult to establish the most appropriate legal framework for detention for assessment/treatment but guidance indicates MCA/DoLS can be used for exploring physical health issues in general hospital, with incapacitated patients¹¹ whereas MHA '83 is only used for the assessment and treatment of adults with/for a mental disorder. Clearly the judgement in this case was that the MHA '83 was more appropriate, indicating that a mental health rather than physical health problem was thought to be indicated from his presentation as being mute and self-neglecting. This is an assumption by the author based on the choice of Section 2 of the MHA '83 being used to the transfer E to Stanage Ward. Further notes submitted to the review state that organic causes were ruled out, although it is not specified what was the basis for this view.

Also, E's physical condition upon admission to Stanage Ward was thought to be poor and a safeguarding referral was raised, presumably for potential neglect of his painful abscesses and shoulder injury. There was no investigation of this and he was returned for a medical assessment, whereupon he was prescribed a course of antibiotics, before being returned again to Stanage Ward.

Once on this ward various possible diagnoses was considered and E was tried on a course of antipsychotic medication, it appears he improved significantly whilst on the ward and taking this medication. This appears to indicate that the medication may have helped his mental state as he became more engaged with ward staff from the 15th October onwards, which led to a decision not to further detain him under S3 MHA.

Records of the MARAC meeting on 19/09/17 show that F's case was planned to be closed within 7 days, due to her non-engagement with the IDVA service, although further opportunities to visit her, whilst E was detained under S2 were not taken, This might have been a useful opportunity to renew engagement with her.

E's improvement on Stanage Ward in the period 15/10/17-17/10/17 led to his legal status being regraded to an informal patient, he was discharged from the Section 2 and then discharged to stepdown care at Wainwright. This indicates that he was thought to be in need of further mental health services upon discharge from hospital, as does his subsequent referral to the Home Treatment Team. Although, notes at the time indicate this was also as he was unable to return home, due to the bail restrictions.

He was clearly more able at this stage, as he did present at SMC for the criminal case, however F as had informed police of her wish to drop the charges, the reason for this

¹⁰ <https://www.kidney.org/atoz/content/what-hyperkalemia>

¹¹ <https://proceduresonline.com/trixcms/media/4395/the-interface-between-the-mental-health-act-1983-and-the-mental-capacity-act-2005-adults.pdf>

is not known, but she as did not attend E had no case to answer and he was no longer subject to bail restrictions. There was nothing to prevent him returning to his home and it appeared that was what happened on this day. This highlights the difficulties in pursuing domestic violence issues through the courts, when the victim retracts her statement, or does not want to attend court to give evidence against a perpetrator.

As he was no longer subject to any lawful restrictions (as his Section 2 had been rescinded as had bail conditions) he left Wainwright Crescent, with 7 days of Olanzapine medication, although he started he would not take this and a care plan for him to followed up in the community by the Home treatment Team. He had minimal engagement with staff during his stay at Wainwright Crescent. While writing his care plan with staff he had a period of absence and shaking which lasted for a couple of minutes. He was advised to see his GP to investigate this, which was thought to be a seizure and a discharge summary was sent to his GP. Both these plans indicate there was thought to be an ongoing need for further treatment of his mental health in the community, on a voluntary basis. E did not attend a GP appointment, nor an appointment with orthopaedic surgeons regarding his old fracture-these were both scheduled while at Wainwright Crescent and he could have been supported to attend these, but its not clear whether staff, nor E was aware of these, which suggest a lack of information sharing between physical and mental health services.

2.3.2. Appraisal Of Practice

As he had discharged himself from hospital with no arrangements in place for his accommodation he again was found having slept rough and being confused about his recent history. He was appropriately admitted on this occasion, with a range of possible physical causes being explored for his poor state. However, as he remained mute and non-cooperative it was unclear whether these were ruled out following tests during this admission. It was appropriate that a DoLS request was raised to require him to remain in hospital on this occasion, to prevent another unplanned self discharge. However, 4 days after this he was further assessed under the Mental Health Act, leading to his detention for assessment under Section 2. As outlined above this indicates a psychiatric, rather than further physical causes for his self-neglect were thought to be more appropriate, leading to his admission to an acute psychiatric service.

Once more a number of possible mental health problems were considered and a trial of anti-psychotic medication coincided with an improvement in his presentation, however the details of this are currently unclear, as police records indicated bail conditions were amended to permit F to visit him on Stanage Ward. These records further indicated he remained mute while on Stanage Ward, so the nature of his progress was unclear. Despite this he was discharged from both his section and the ward after 26 days, with no clear diagnosis having been made. Despite this he was referred to the Home Treatment Team¹² (HTT) and was visited at Wainwright Crescent, where he stayed for 6 days.

¹² <https://www.shsc.nhs.uk/services/home-treatment-team>

When seen by the HTT he did not know why he had been in hospital and denied self-neglect, showing he had no insight into his condition, or need for after care. This is not uncommon in recently discharged patients and the staff at Wainwright Crescent noted it was unlikely he would comply with treatment or follow up informally. Despite this he was then discharged for the HTT to attempt to follow him up at home. The potential risks to F of this plan do not appear to have been considered as part of this plan and she was not offered a carer's assessment which were gaps in practice based on information available to the Review. She had been invited to the ward but declined when told she would not be able to see E.

There were 3 potential safeguarding issues arising from this period;

- the first being that when E returned home he would pose an ongoing risk to F of further coercive control and domestic abuse
- the second that given his lack of insight and limited engagement there was a high risk he would continue to self-neglect when he returned home.
- The third related to his account of how he broke his arm, which he explained as a result of falling downstairs, he did not seek medical attention at the time, as his partner had suffered a bereavement and he didn't want to leave her.

If these risks were considered there was no safeguarding process instigated at this stage, which was a gap in practice by the Mental Health Services. He had 2 appointments for follow up of his physical health (with GP and orthopaedics), but did not attend either. Wainwright Crescent staff were made aware of these, which suggest information was not shared between the services.

2.3.3. Summary Of Learning

- **E's third attendance at the ED led to his first detention being requested under DoLS, due to him being deemed to be incapacitated for the decision regarding treatment in hospital**
- **Consideration of lawful powers to detain E led to a decision to use Section 2 of the MHA'83 rather than DoLS and his transfer to psychiatric inpatient services**
- **The decision to discharge E from his Section 2 (MHA'83) and the ward after 26 days, was made as he had improved in the final days of his admission**
- **He was referred to a step down service from the ward and then to the HTT, as he was thought to need ongoing mental health treatment.**
- **F was not including in discharge planning, therefore the potential risks of further domestic abuse were not reviewed when this decision was made**
- **F had been closed to the IDVA service as she did not engage with them and decided not to give evidence against E at court, therefore he had no case to answer and returned home on the same day**
- **F received no further support from DA services despite E returning home and being a known risk to her**
- **No safeguarding process was followed to manage the risk of either DA or Self-neglect**
- **Possible lack of information sharing between GP and STH with SHSCP about medical appointments**

2.4. Key Practice Episode 4: (25/10/17-22/11/17)

E had returned home from the step-down service after the criminal charges against him were dropped at court. The HTT attempted to contact E at home 3 times on the first 3 days after he went home. 2 “cold call” attempts were made to visit him at home without an appointment but without any reply, and not seeing E. It is not clear whether he was at home at this time, although it was assumed that he was. A further 3 days after this E did go to his GP where he was examined and found to be unwashed, malodourous and was prescribed swabs for abscesses and a further course of antibiotics. He stated that he had had no contact from HTT, despite the 3 attempted contacts from them.

The GP planned to see him again in 2 weeks and noted that there were no clear plans for follow up. He planned to chase up the mental health team about their involvement, but there were no records of a call to the HTT. However, on the same day the HTT discharged him following a MDT discussion and having not seen him, despite the 2 attempted visits. This could have been informed by the fact he had been in to see his GP and stated to his GP he hadn't had follow up by HTT.

E's case was then referred to the local Recovery Team by the HTT and subsequently a worker from this team made 3 further attempts at unannounced home visits over the next 10 days, all of which were unsuccessful. A social worker (from Recovery Team) then wrote to his GP to say that above attempts were made and a further visit was going to be planned, possibly with the police. A letter was then hand delivered to E's home address to inform him of another visit scheduled for the next day.

On the next day E called the Recovery Team and said he did not want any further contact with mental health services, during this call he was deemed to appear clear and articulate. Notes state that his delirium on admission could have caused by his infected boils. His case was then closed to mental health services, without him being seen following his return home. There were no records of a discharge summary being sent to the GP by either the HTT, or Recovery Team and no records of whether the planned 2 week follow up appointment ever happened with his GP at the surgery and no are no more records of contact with E by any service from this point.

2.4.1. Significance

This KPE shows the difficulties that community mental health services have when attempting follow up with clients in the community after they have been discharged from hospital, when they do not respond to home visits or phone calls. Both the HTT and then the Recovery Team did make a series of attempts to see E but due to his lack of response both services closed his case. This was presumably standard practice by the HTT and Recovery Team but could have been better informed by the fact he had been in to see his GP and stated to his GP he hadn't had follow up by HTT.

It was interesting that E did engage with his GP albeit briefly, attending the surgery he had an examination and accepted some treatment for his ulcers.

Despite his continued lack of self-care he was able to engage in some discussion with his GP, who planned on further monitoring and follow up, but it does not appear this subsequently took place. He did tell his GP he had not been followed up by the HTT and had no contact with him, although they had in fact tried to visit him at home 2 or 3 times. If the HTT had been aware of his attendance at the surgery it was possible this could have been a means of engaging with E. No communication was made with F by either mental health team, to try to enlist her help in facilitating a visit for follow up, nor to inform her that they were closing his case. There did not appear to be a consideration of the risks to her of further violence, nor to E of returning to risks of self-neglect. A significant aspect of E's issues was his excessive consumption of strong alcohol to the point that he had required a detox when in hospital. This did not seem to be addressed further by any service prior to his discharge. It was also noted he repeatedly denied any problem with alcohol when previously assessed in hospital, despite clear evidence to the contrary.

Also, he did make telephone contact with the Recovery Team and presumably this was in response to the hand delivered letter, which notified him of a further home visit. After this call his case was closed to the Recovery Team at his request. At this point he was lost to all services so whether his mental and physical health further deteriorated again when he stopped taking Olanzapine is not known. Clearly he had benefited from his previous period in hospital, especially he was noted to have improved in his final 2-3 days on Stanage Ward, although whether this was due to the anti-psychotic medication, the detox, or the treatment for his infections was not clarified. There appeared to be an assumption that his delirium on admission was due to his physical health and he did not have any underlying serious and enduring mental health problem, at the point he was closed to mental health follow up. This was not clarified or further explored as he was not seen alive again by any service.

2.4.2 Appraisal of Practice

It was good practice by the HTT to attempt rapid follow up in the community (25/10/17 - 27/10/17) and they did try 2 unannounced home visits, after unsuccessfully trying to call E to arrange an appointment. However no alternative approaches were tried prior to him being discharged on 30/10/17) due to his non-engagement. Given the risks of both further self-neglect and DA in this case, this appears to be premature decision.

It also appears to have been taken without consulting/communicating with his GP, who had seen E the same day and could have updated HTT about his condition, as he was already showing significant signs of further self-neglect when he visited the surgery. This was a gap in practice, with both agencies working separately rather than together. It was a further gap that F had not been informed of either the HTT attempts to visit, nor the plan to close his case. This is relevant as potentially F could have helped facilitate a visit, if she had been part of discharge and aftercare planning for E. This was not done and his case was closed to the HTT within 5 days of first trying to visit him.

He was not closed entirely to Mental Health Services however, as when HTT closed his case they referred him to the Recovery Team for further attempts to follow him up. This presumably indicated that the HTT felt that he did still require follow up, in which

case it is not clear why they handed responsibility for this over to colleagues in the Recovery Team, rather than keep his case open to their service.

The discharge summary sent to the GP by the HTT did include some history about his self-neglect, alcohol detox and the quantity of cats/faeces in his property. It did not contain a plan for managing the risks of ongoing self-neglect.

There was some appropriate practice by workers from the Recovery Team, who attempted a further 3 home visits over the next 10 days. However, again they did not attempt to liaise with his GP, nor with F. These visits were unannounced and unsuccessful, so it was also positive that another strategy was attempted to engage him. This was to hand deliver a letter to his address to inform him of the need to be seen and to possibly involve the police if needs be in this. To some extent this was successful as E did respond to this, by telephoning the Recovery Service the next day.

However, his case was closed by the service the same day, as he said he did not want to be seen by them. This decision by the team to rapidly close his case at his request appears premature with the benefit of hindsight. However, even at the time it would have been reasonable to require him to accept at least one visit, so he could be seen preferably at home prior to a decision to close/keep open his case. There appeared little attempt to engage him before his case was closed, which was a gap in practice, as was the lack of communication with his GP and partner about the decision to close his case.

2.4.3 Summary of Learning

- **There was no successful communication with E, nor his partner F prior to HTT deciding to close his case, 5 days after the first attempt to see him, which appears premature.**
- **E's GP had seen him, but HTT were not aware, as there was no discussion prior to his case being closed**
- **Unannounced Home Visits are sometimes successful in seeing clients, but not in his case, despite this the same approach was attempted by both HTT and Recovery Team workers.**
- **Recovery Team worker did have a telephone conversation with E after a letter was hand delivered, but the same day his case was closed without seeing him, as his request.**
- **He should have been seen at least once, preferably at home, before his case was closed.**
- **There was no further communication with E, by his GP about the treatment for his infections, or any ongoing other health issues relating to his alcohol use, or mental health issues.**
- **E was lost to all services from this point on until his body was discovered 2 years later.**

2.5. Key Practice Episode 5: (09/08/18-14/09/18)

This is the final period of contact before E's body was discovered and covers a brief hospital admission and subsequent outpatients appointments for F, for an infected leg wound. It is not clear what this wound was caused by and whether it related to domestic violence from E. The hospital notes at the time stated that F attended the

Emergency Department on 08/08/18, for an infected wound in her left lower leg, thought to be 5 days old, from tripping over the stairs. F was treated with antibiotics and was discharged home the same day with oral antibiotics. During F's treatment, notes also stated that DA was discussed with her. This issue could have prompted a re-referral into MARAC as a repeat case if it was found to have been DA related.

F was seen on a further 5 occasions as an outpatient for review over the next month and needed repeated re-dressing of this wound, so presumably it was quite bad, but again no details were supplied to the Review about this.

2.5.1. Significance

It is difficult to make a judgement about the significance of this wound and its subsequent treatment as an inpatient and then in the community, given the limited information available. Clearly it was quite a serious wound which needed 3 days in hospital and 5 follow up outpatient appointments to dress this, which F did engage with before she was discharged from the outpatients dept.

2.5.2. Appraisal of Practice

The reason suspected for the injury would have been useful to know for learning from this case, as this was the only point of contact with F subsequent to E return home. The wound may have been an indication of further self-neglect/insanitary living conditions (as it clearly had been infected quite badly before F went to hospital) or of further domestic violence from E. It was noted F claimed it was due to an accident.

Clearly there had been some discussion with F about domestic violence while she was an in-patient, but without knowing the content of this discussion it cannot be appraised, but may indicate a lack of knowledge about F having been subject to DA previously, or a lack of professional curiosity about this. No referral was made to any DA service, or the police-this could be a gap in practice, although without details of the discussion this can only be a tentative appraisal.

2.5.3. Summary of Learning

- **There appeared to be a lack of professional curiosity about the cause of the wound to F and no referral, or information sharing about the risk of further suspected DA.**

2.6. Key Practice Episode 6. (05/07/19-06/07/19) Discovery of E body and autopsy

A phone call to the police by a neighbour alerted the police that E had not been seen for some time and F was heard shouting at someone. Police attended and found the property in an extremely neglected condition, with cat faeces widespread throughout. E's body was discovered in an upstairs bedroom. He had been dead for months, had decomposed and parts of his limbs had been eaten (presumably by the cats which were kept in the house). F was arrested but later released on bail. An autopsy was

undertaken, which revealed a number of fractures to E, arm, shoulder and ribs at various points before he died, but his body was too badly decomposed to conclusively determine the cause of death.

An inquest was heard in January 2021, with the following narrative verdict; *“Mr E was pronounced deceased on 5 July 2019 at his home address, his medical cause of death remains unascertained. Given the time period between the likely date of death (January 2019) and the discovery of the body, the court is unable to confirm how Mr E came by his death.”*

2.6.1. Significance

This period demonstrated that F and E had continued to reside together after services ceased their involvement with them. The self-neglect of the home environment had clearly not improved since E hospital admission and also F appeared to be significantly self-neglecting as well. E died at some point after 10/17 but had lain undiscovered and unreported by F for a number of months, but details of this are not currently known. Due to the state of decomposition the cause of death could not be ascertained. F was arrested then bailed, CE are still deciding whether to bring charges vs F for prevention of a lawful burial for E (therefore they have advised she is not spoken to yet as part of this review).

2.6.2. Appraisal of Practice

There had been no attempt to follow up F, or E from the previous last contact with F in hospital, where she had needed treatment for an infected leg wound, which was a gap in practice. It appeared that the previous serious self-neglect by E and F was known, but did not lead to any further attempt to assess or manage this, during the period from October 2017- July 2019. As above, due to the length of time his body lay undiscovered it was not possible to identify the cause of his death, however it would appear the condition of his body and home environment showed significant signs of further chronic issues of self-neglect.

2.6.3. Summary of Learning

- **Where an adult had been known to seriously self-neglect prior to contact with inpatient and community mental health services, this was likely to continue and should require regular attempts to monitor and assess this, rather than to close his case to any further follow-up.**
- **The lack of oversight of the risks of self-neglect was not in accordance with the multi agency self-neglect policy and procedures.**

3. Review Terms of Reference, Findings and Recommendations

This section contains priority findings that have emerged from the SAR. The findings explain why professional practice was not more effective in protecting the adult in this case. Each of the original Terms of Reference are considered, with examples taken from the work undertaken in the case.

3.1. Terms of Reference 1. Evaluate the Appropriateness and Coordination of Multi-Agency Interaction, Communication and Support provided to Adult E.

There was limited and ineffective ongoing multi-agency interaction and communication regarding assessment and management of risk of either Domestic Violence from E to F, or of Self Neglect by E. E did receive support whilst in both general and psychiatric hospital, but this was disjointed and did not lead to any effective support following his discharge from any admission. This was partly due to his non-engagement with offers from Community Mental Health Services, but his case was rapidly closed to services without him being seen. He received no service from Adult Social Care, despite a number of safeguarding referrals, which were sent onto Mental Health although at the time he was not known to them.

3.1.1. Finding 1

Discharge from inpatient care does not always lead to effective handover of responsibility to relevant community services, leaving adults at risk of further self-neglect.

Example from the Case

E was brought to hospital on 3 occasions, the first occasion he was not admitted, but discharged back to police custody. Due to bail conditions he slept rough until he was found by a member of the public who phoned an ambulance, leading to his being returned to the hospital. On the second occasion he was then admitted, but discharged himself against medical advice, which was not communicated to any community team, resulting in him once more sleeping rough until found again by a member of the public who called an ambulance. He had been bailed to a hostel in Hull, but without any viable means or support to attend there. On the third occasion he was admitted and subsequently detained under the Mental Health Act, before being transferred to psychiatric hospital. He was discharged from psychiatric hospital, with a referral to Community Mental Health on this occasion.

Recommendations for the Board to Consider

- **All specified public authorities subject to the Duty to Refer requirement within the Homeless Reduction Act 2017 shall assure themselves and the SASP that they have the required procedures in place to refer someone who they consider may be homeless or threatened with homelessness and that procedures are being followed.**

3.2. Terms of Reference 2. Identify any missed opportunities for agencies to intervene and affect a positive outcome during the timeframe for the review. (including after the submission of 3 safeguarding concerns and the referral to MARAC).

There were several missed opportunities to intervene with E about his self-neglect, as none of the Safeguarding Concerns were acted on, but forwarded on to Mental Health without being appropriately triaged first by Adult Social Care Services. On both these occasions E was not known to Mental Health and there were no records of any action taken to attempt to engage with E after these concerns were reported. Also, the MARAC process was ineffective, with engagement only directed to support F by IDVA services, which she did not engage with. Both the safeguarding concerns and MARAC processes were closed without E, or F having been seen by any community health or social care service. Opportunities to co-ordinate care and exchange information with the GP were not taken when this would have provided useful insight into E's condition and attitude to the help he was offered.

Finding 2

Where adults are simultaneously subjects of both MARAC and Safeguarding Referrals, insufficient triaging of referrals and a lack of information sharing can negatively affect the likelihood of positive outcomes for both processes.

Example from the case

The case was discussed at one MARAC meeting, but the case was closed, without information having been shared that E had been admitted to hospital. The risk of further DA from E was not assessed nor managed, other than by his arrest for repeatedly breaching his bail conditions not to contact, or reside with F. From the original referral to MARAC it appeared that the DA had escalated when E also began to self-neglect, possibly indicating the violence was related to his poor state of mental health and alcohol consumption. The relationship between his mental state, alcohol use, self-neglect and domestic violence was never properly explored during any hospital admission. As outlined above, the safeguarding concerns were not responded to which did not lead to any shared decision making about risk assessment or management.

Recommendations for the Board to consider

- **Any safeguarding referral for self-neglect needs to be triaged and recorded by Adult Social Care, transferred to Mental Health Services in a timely manner for next steps. A draft process map will be developed to support this.**
- **For Adult Social Care to consider setting up a Multi Agency Safeguarding Hub (MASH) to ensure all referrals for Safeguarding are effectively reviewed and triaged prior to any decision to transfer the referral to any other agency (e.g. Mental Health Services) to follow up**
- **Where adults are referred to the MARAC process, information sharing by agencies should ensure that any referrals for safeguarding (of either the victim or perpetrator) are included as part of the discussion.**
- **Where MARAC discussions identify ongoing risks to the adult consideration needs to be given as to whether the case can be monitored by a lead agency (such as GP, Housing, Police) as agreed at the MARAC.**

3.3. Terms of Reference 3. Assess the effectiveness of the actions agreed at MARAC (or VARMM) in keeping the people in this case safe.

The case was discussed at the MARAC on 19/09/17, with a summary of the escalating violence from E to F recorded. It was known that F had bruising and cuts, that E was

using controlling behaviour and preventing F leaving the house. It was also known that E had been bailed and had been admitted to hospital, with the IDVAs also updating from a telephone contact with F that she felt it was his mental health making him abusive and that he had been sectioned, so she was able to return home.

The actions agreed were for IDVAs to continue to work with F and for SYP to check F's employment status as a care worker to consider whether a LADO¹³ (Local Authority Designated Officer) referral was required. The case was closed following this meeting and so the outcome of the SYP action is not known and furthermore it is not known whether F provided a care service to adults or children, the LADO role is only relevant for carers working with children, although since this time a similar process has been developed for carers working with adults¹⁴. There was no evidence that action was taken to refer F through either the LADO, or PiPoT process.

Also, as IDVAs at that time were mainly offering telephone support there was limited effectiveness of the support as F did not engage with telephone calls, either to herself or via her friend and on this basis it appears her case was closed to the IDVAs and the MARAC process. There was no evidence that the case was discussed at a VARMM¹⁵ (Vulnerable Adults Risk Management Model) meeting. Overall the MARAC process did little effective action to keep F safe and the case was closed quite rapidly after discussion at one meeting, which was in line with the policy whereby cases are only heard at the MARAC again if there is a repeat incident within 12 months.

Finding 3

The MARAC process should have put in place a multi-agency plan to engage F, instead the IDVA case was closed prior to a risk management plan for the victim of domestic abuse being agreed, which may lead to adults continuing to be at risk from further domestic abuse, especially where criminal processes are dropped and the couple continue to live together.

Example from the Case.

In this case the IDVA case was closed after one MARAC meeting, as F did not engage with offers of telephone support from IDVAs. It was not known at this stage whether E would be successfully prosecuted and in fact the case was dropped as F did not attend the court case to give evidence. It was further not known that F and E would return to live together and she was not effectively protected from further DA.

Recommendations for the Board to consider

- **Where MARAC cases are subject to Criminal Justice processes, Police should continue to encourage engagement with IDVAs while these processes are ongoing and IDVAs will reopen the case as soon as the victim wishes to engage.**

¹³ <https://www.safeguardingsheffieldchildren.org/sscb/safeguarding-information-and-resources/allegations-of-abuse-against-people-who-work-with-children>

¹⁴ https://www.sheffieldasp.org.uk/assets/1/pipot_protocol_final_version_0.2.pdf

- If victims of DA are also subject to coercive control they may not be able to make informed decisions about protecting themselves from further abuse, therefore a reluctance to engage with support should not be seen as a reduction in risk. Consideration should be given to a lead agency continuing to monitor and assess risks if this is possible.
- The case should be re-referred to MARAC for further discussion if additional high-risk factors/further incidents are disclosed to any agency.

3.4. Terms of Reference 4. Recommend any additional follow up processes that should be in place where adults are not in touch or in contact with services.

A number of potential processes were available for support of E and F, but were not used effectively in this case;

1. The IDVA case and MARAC processes were closed prior to effectively managing the risk of DA to F from E.
2. Safeguarding Adults/Self-neglect Procedures were not instigated after 3 referrals for E, in relation to his risk of self-neglect.
3. VARMM processes were also in place, but were not initiated in this case.
4. CPA¹⁶ (Care Programme Approach) was available to coordinate aftercare for E following his discharge from psychiatric hospital.
5. Annual Health Check reviews at the GP practice were available to ensure that E' health was monitored in the community.

Therefore, whilst no additional processes are needed, the ones that are available to monitor risks in cases of DA, or Self-neglect were either not effectively implemented at all, or were closed prematurely due to non-engagement, leaving both adults at risk of further harm without sufficient follow up by any agency.

Finding 4

Where adults remain at risk from either domestic abuse or self-neglect the range of processes in place to protect them are either not used at all or closed before they make any significant difference to risk.

Example from the case

The IDVA case was closed after one MARAC meeting when the risk of F and E returning to live together was not known, or assessed. The Safeguarding referrals were passed on, but not assessed and no safeguarding procedures were used in this case. The VARMM process was also in place but E was not referred to this process by any agency. It was unclear whether E ever had a CPA care coordinator or CPA care plan, but his case was rapidly closed after he left hospital and following a series of unsuccessful home visits. E was seen by his GP after he left hospital once, but he was not followed up for any health check, despite evidence of chronic self-neglect and problematic alcohol use.

¹⁶ <https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/>

Recommendations for the Board to Consider

- **Where referrals are made following safeguarding concerns about severe self-neglect these are assessed for action under either The Care Act 2014 S42 duties by the local authority or the VARMM processes, prior to the case being closed.**
- **Where adults are discharged from inpatient mental health services, their case is not closed until they have been seen and a team discussion has taken place. In occasional case's the team discussion may agree a clinical rationale to close a case discussed without being seen.**
- **When any agency identifies an individual who is at risk of continued harm from self-neglect they inform the GP and invite the Practice to contribute to any subsequent multi-agency meetings.**

3.5. Terms of Reference 5. Evaluate the Support Provided by the IDVAS.

During the period subject to review the IDVA service was provided by Action Housing. At this time the IDVA service was based at a police station, prioritised High Risk Cases and offered mostly telephone support but face to face appointments as part of assessment were encouraged.. Following a referral from the Police (31/08/17) there were 4 attempts to call F, and 1 call to a friend she was staying with. On the first occasion there was no answer and no message left, in case E was still at the property (he was known to be in hospital at the time). On the second occasion a voicemail was left on both F's and her friend's phone, requesting she get in touch.

After the MARAC meeting a further call was attempted to update F on the meeting, which was not answered. Additional action for IDVAs after the MARAC was to establish E's whereabouts via Probation and then to close the case. E was not known to Probation and a final call to F was not answered. A final opportunity was identified to see F at Court, but this was also unsuccessful as she did not attend. Following information that F wished to resume her relationship with E the case was closed.

From the records submitted it does not appear that IDVAs ever actually spoke to F directly before closing her case, which may have been according to policy, but was clearly ineffective in establishing the degree of risk she was subject to or helpful to her in managing this.

Since the review, in 2019, the IDVA contract has been awarded to a new provider, IDAS¹⁷ (Independent Domestic Abuse Services), who seek to be more creative in how people at risk are engaged with and aim to offer more face-to-face support. The IDVA review noted that it was difficult to know when it would be safe to contact F and that E was known to limited agencies, but while there had been some multi agency liaison, the IDVA service did not take advantage of E's period of inpatient care to seek to visit F and only call was attempted during the month he was in hospital.

Finding 5

Where adults are referred to the IDVA service, there needs to be a plan agreed at the MARAC to establish both the victims' and perpetrators' whereabouts through better information sharing with health, social care and police services,

¹⁷ <https://www.idas.org.uk/about-us/>

to seek a safe opportunity to visit the adult and undertake risk assessment and safety planning in person, rather than over the phone. Where possible these visits should be undertaken jointly with an appropriate professional involved in the case.

Example from the Case

As set out above, there were a series of errors in the case, where it was thought E was known to probation (he was not known), it was also thought he was residing in a bail hostel when he was in fact detained in hospital under S2 MHA '83. Furthermore it was not clear from the records what F's employment as a carer was and when she might be not at work and available to discuss the domestic abuse. Also, the case was closed when she did not attend to give evidence at court, which was potentially when she was at most risk of further harm from E, who then returned home to live with her.

Recommendations for the Board to Consider

- **IDVA's to work with multi agency partners through the MARAC process and establish the whereabouts of both perpetrators and victims of abuse, on an ongoing basis.**
- **Where partner agencies are aware of the IDVA involvement in a high risk case, they should proactively work with IDVAs, updating them on relevant plans, hospital admissions and opportunities for joint work to establish and manage risks of ongoing DA**
- **That IDVAs do not automatically close a case if the couple return to reside together, as the risk of DA is liable to escalate at this time.**
- **That resources are sufficient to manage the increased demand for DA support, especially for IDVA's having the time to seek engagement assertively and creatively with the most complex cases.**

3.6. Terms of Reference 6. To identify learning in multi-agency work with people who self-neglect, including risk assessments and proportionate professional intervention.

The common issues for improving practice when working with people who self-neglect may often include a combination of the following;

- Assertive outreach to develop a rapport and engagement with the adult.
- Understanding the background and context within which the adult has self-neglected.
- Assessing how long it has been occurring and diagnosing any underlying conditions/reasons for the change in behaviour.
- Treating any physical or mental health problems that have been identified.
- Assessing Capacity and Risk on an ongoing basis.
- Managing the risks to health and welfare caused by the self-neglect
- Consideration of the threshold for the use of any statutory powers relevant to require the adult to comply with Care and Treatment, whether in hospital or the community.

- Information sharing across partner organisations to agree both overall case responsibility and shared decision-making.

In this case there were no multi agency meetings to consider the risks to E of his self-neglect and no shared community plans in place to manage the risk once he had left hospital. Despite several admissions to hospital he was never formally diagnosed with a physical or mental health problem, although he did receive some treatment as an inpatient in both general and psychiatric hospital, this did not continue when he returned home.

Although attempts were made to work with him in the community, his non-engagement with the HTT and Recovery Team led to a rapid case closure, without any ongoing oversight of the risks to him. He was not followed up by any service for the last 2 years of his life and the condition which he was found in, when his body was discovered by the police indicated that the severe and chronic self-neglect continued without any input from any Health or Social Care Service.

Finding 6

Adults who self-neglect may fall outside the eligibility criteria for traditional Social Care services and be lost to all agencies if the VARMM Policy and Procedures are not instigated.

Example from the Case

In this case, it appears that whilst E was known to be self-neglecting by Mental Health, Adult Social Care, Primary Care, Hospital Care & the Police, no agency referred E for the VARMM process and there was no multiagency work done to assess or manage the ongoing risks to his health and wellbeing.

Recommendations for the Board to Consider

- **Review the Multi-agency policy and procedures for managing Self-Neglect, the VARMM process to ensure that it is up to date**
- **Request/undertake an independent audit of all local agencies compliance with this policy, where adults are known to the agency to be experiencing significant self-neglect.**
- **Where necessary commission training to support best practice with adults who self-neglect in Sheffield.**

3.7. Terms of Reference 7. To identify learning in how professionals work with people who refuse to engage with them and who persist in risky behaviours. (discharge/alcohol)

In this case, E did not engage with offers of support for his mental health and was rapidly discharged from mental health services, after he left hospital. When this was done, it was unclear whether he was thought to have an ongoing need for treatment and management for his mental health, which potentially put him at risk of further serious self-neglect. Furthermore, F identified the decline in his mental health as a significant risk factor for domestic violence, including coercive control. At the time of discharge he did make telephone contact the Recovery Team to state he did not want services, in response to a letter requesting he make contact to arrange an appointment and including a potential police welfare check to ensure he was seen.

It appears that he was then discharged without being seen and further it seems that his self-neglect continued without further attempts to see him by any service. At some point in the next 12-18 months he died at home and his body lay undiscovered until neighbours called the police, to alert them of shouting from his address.

Mental Health Services did notify his GP of his discharge from the HTT, but not from the recovery Team. His GP had prescribed him antibiotics for his infected sores, but did not see him again after this time for any further follow up. The outcome of this case clearly indicates the risk of discharging non-engaging patients who self-neglect from services. It appeared that while efforts had been made to see him in the community his lack of engagement was accepted at face value, rather than prompting any further consideration of the risks he posed to himself and others and whether statutory powers could be employed to achieve his compliance with care, treatment or monitoring at home. The issue of his alcohol consumption was addressed initially be a detox in hospital, but the potential impact of this on his longer-term physical health was not identified as a cause for concern, or action. He denied any problems with alcohol when he finally engaged at the end of his psychiatric admission but this was not challenged or otherwise pursued directly or through referral to alcohol services.

Finding 7

When people do not engage with aftercare by mental health services in the community, this may be accepted as a reason to close the case, leaving the adult at risk, rather than escalate the case to the VARMM process for ongoing multi agency involvement.

Example from The Case

See above section, which summarises the involvement of HTT and Recovery Team in KPE 4, when his case was closed there were no onward referrals for primary care or social care agencies to pursue any further attempts to engage and support E, or F.

Recommendations for the Board to consider

- **Ensure all mental health staff are aware of the risks of self-neglect when people are difficult to engage and decisions about case closure, or transfer are made after sharing information with other involved agencies, as part of the VARMM procedures**
- **Where adults are known to be at high risk of self-neglect and alcohol dependency agencies need to work together with appropriate input from alcohol services, either using VARMM or as part of multi-agency safeguarding procedures.**

3.8. Terms of Reference 8. Consider multi agency responses to someone who repeatedly misses appointments (including after periods of inpatient care for mental health illnesses).

E did not have a planned appointment for a home visit by HTT after he left hospital. He was telephoned to arrange an appointment, which he did not respond to. This led to 2 further attempts to see him, by cold calling to his address over the next 2 days. As he did not answer the door his case was closed to the team and transferred to the

Recovery Team, who also attempted 3 cold call visits to see him. He also did not respond to these, but when a letter was left with him, he did call the Team and declined to have further contact with them and they closed his case. This was interesting in that the letter included a reference to a Police Welfare Check and this may have prompted him to call in order to avoid this, which it did successfully as his case was then duly closed.

There was no multi agency response and no further visits were attempted. The learning from this is largely outlined in the previous section, but further attempts to visit him should have been made and creative solutions to engage him tried prior to the decision to accept his non-engagement. No additional Finding for this aspect of the case, it is covered above through Finding 7

3.9. Terms of Reference 9. Evaluate evidence submitted for significant changes in circumstances (between September and October 2017) that triggered the repeat hospital admissions?

E had 3 appearances at hospital within a short space of time, on the first occasion he was brought to A&E by police after his arrest (03/09/17) at which he was not admitted as no treatment was thought to be needed. The second occasion was when a member of the public called an ambulance after seeing him on a bench (05/09/17), at which he was admitted for a week and suspected to be suffering from Urosepsis and Alcohol withdrawal. He had required sedation due to his agitation and then left hospital against medical advice (12/09/17). Following his re-arrest, for breaching bail conditions he was once more found on a bench by a member of the public and returned to A&E by ambulance (14/09/17). On this occasion acute renal failure was suspected and he was re-admitted. He was prevented from leaving hospital again by a request for a DoLS on (15/09/17) before being transferred to mental health services under Section 2 (19/09/17). He was briefly returned to hospital the same day and seen in A&E for treatment of infected boils.

He was therefore seen 4 times in A&E within 2 weeks and from available records appeared to present in a very similar fashion on each occasion. If this was the case then the decision to admit and treat him formally in his Best Interests could have been taken on the first presentation, which would have avoided E spending the time between presentations sleeping rough, or in custody. There appeared to be a reluctance to admit him initially, the reason for which is not clear from the records, but it appears he was thought to have a social rather than a medical problem.

Finding 9

Adults who attend A&E in a state of severe self-neglect may not be admitted or detained in hospital, when they are subsequently returned to hospital and then found to be in need of urgent medical assessment and treatment, which they lack insight into.

Example from the Case

As set out above, E was known to be in a very poor physical condition on all 4 of the assessments at A&E, which occurred within 2 weeks. The decision not to admit and detain him formally was not taken until his 3rd presentation, which led to him suffering avoidable harm by sleeping rough and not having medical care which he needed in

his Best Interests. His physical health was not deemed to be a priority for treatment the first time he was seen, but subsequently sepsis and renal failure was suspected which could have had serious consequences for him. Furthermore, he was mute and refusing treatment on all his appearances in hospital, clearly indicating some cognitive impact/deterioration and giving grounds to doubt his capacity.

Recommendations for the Board to Consider

- **Adults frequently presenting to hospital A&E who are in a state of chronic self-neglect, which they lack insight into, should be assessed thoroughly, including where appropriate a capacity assessment, before a medical decision is taken not to admit them to hospital for further assessment and treatment.**

3.10. Terms of Reference 10. Review practice in this case regarding GP annual reviews and the support might these have provided

The GP was copied into correspondence from other agencies (mental health and hospital) regarding his admissions and treatment while in Stanage Ward and in Ward 1 NGH, as well as his discharge from the HTT. These documents referenced the concerns about his self-neglect, the risk to F and his prescribed medication. The GP was the last professional to see E when he attended an appointment on 02/11/17, at which he was prescribed a course of antibiotics for his abscesses and stated that he did not want to continue taking the antipsychotic medication prescribed on Stanage Ward. A follow up appointment was not made and no annual review was arranged for him. If E had been known to have a SMI (Serious Mental Illness), this would have been flagged on his medical records and the policy for such patients is to invite them for annual physical and mental health reviews, as per national guidance¹⁸.

It would have been good practice for the GP to have offered E a further appointment, as whilst the GP had been made aware that he was not engaging with other services he clearly had engaged, at least to some extent with his GP. The GP had not been made aware of the MARAC, or IDVA involvement in the case of E or his partner and did not proactively discuss the information provided about E's self-neglect, or alcohol use with him. The GP did not attempt to see E at home or at the surgery again.

Finding 10

Where patients are discharged from mental health services without a clear diagnosis of a Serious Enduring Mental Illness, this does not trigger an annual health review by their GP, who may then not see the patient regularly to assess their mental and physical health.

Example from The Case

The discharge summary from Stanage Ward and subsequently the Home Treatment Team did include information about E being prescribed antipsychotic medication, but did not include a definitive diagnosis. E was not automatically flagged up on the GP records for an annual review. The GP in this case was aware that E had been discharged from a range of services and was experiencing self-neglect, including on

¹⁸ <https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care-annexes.pdf>

his last appointment at the surgery. This did not prompt the GP to proactively follow up E in the community, or to share information with other services.

Recommendations for the Board to consider

- **When any agency identifies an individual who is at risk of continued harm from self-neglect they inform the GP and invite the Practice to any subsequent multi-agency meetings**
- **CCG to also ensure GPs are aware of the need to share information about patients known to be experiencing self-neglect, in line with the Multi-Agency VARMM policy.**

Mick Haggar

Independent SAR

Report Author

January 2021

Appendix 1

List of Abbreviations used in the report

Abbreviation	Full Version	Explanation
SASP	Sheffield Adult Safeguarding Partnership	<p>The Sheffield Adult Safeguarding Partnership is a statutory multi-agency forum for agreeing how services, agencies, organisations, businesses and the communities work together to safeguard adults who may be or are at risk of abuse and neglect. It seeks to work closely with and for those people most at risk of harm from abuse and neglect within Sheffield.</p> <p>Its main purpose is to ensure that agencies work together to effectively safeguard and promote the safety and wellbeing of adults (primarily with care and support needs) within Sheffield. The partnership aims to promote awareness and understanding of abuse and neglect within Sheffield City. It also seeks to ensure that systems are in place to protect people from abuse and neglect and that safeguarding arrangements are monitored and improved as a result of effective and robust challenge.</p> <p>The three core duties of the Safeguarding Partnership under The Care Act 2014 are to:</p> <ol style="list-style-type: none">1. Publish a Strategic Plan (2017-2020) (click on link)2. Publish an Annual Report (2017-2018) (click on link)3. Conduct Safeguarding Adult Reviews of serious cases.
SAR	Safeguarding Adult Review	<p>A Safeguarding Adult Review is a multi-agency process that considers whether or not serious harm experienced by an adult or group of adults at risk of abuse or neglect, could have been predicted or prevented and uses that consideration to develop learning that enables the partnership to improve services and prevent abuse and neglect in the future.</p>

		<p>The SAR Sub-Group of the Sheffield Adult Safeguarding Partnership (SASP) is responsible for recommending the commissioning of Safeguarding Adult Reviews (SARs) in line with the Care Act 2014 Guidance (Chapter 14), managing the process and assuring the Sheffield Adult Safeguarding Partnership those recommendations and actions have been addressed by the partnership and individual agencies.</p>
<p>Section 2 MHA '83</p>	<p>Section 2 of Mental Health Act 1983</p>	<p>Section 2-Admission for assessment.</p> <p>(1) A patient may be admitted to a hospital and detained there for the period allowed by subsection (4) below in pursuance of an application (in this Act referred to as “an application for admission for assessment”) made in accordance with subsections (2) and (3) below.</p> <p>(2) An application for admission for assessment may be made in respect of a patient on the grounds that:</p> <p>(a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and</p> <p>(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.</p> <p>(3) An application for admission for assessment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with.</p> <p>(4) Subject to the provisions of section 29(4) below, a patient admitted to hospital in pursuance of an application for admission for assessment may be detained for a period not exceeding 28 days beginning with the day on which he is admitted, but shall not be detained after the expiration of that period unless before it has expired he has become liable to be detained by virtue of a subsequent application, order or direction under the following provisions of this Act.</p> <p>https://www.legislation.gov.uk/ukpga/1983/20/section/2</p>

KPE	Key Practice Episode	<p>Building on the work of Charles Vincent and colleagues (Taylor-Adams and Vincent, 2004) we have coined the term ‘key practice episodes’ to describe episodes from the case that require further analysis. These are episodes that are judged to be significant to understanding the way that the case developed and was handled. They are not restricted to specific actions or inactions but can extend over longer periods. The term ‘key’ emphasises that they do not form a complete history of the case but are a selection. It is intentionally neutral so can be used to incorporate good and problematic aspects.</p> <p>https://www.scie.org.uk/publications/guides/guide24/concepts/episodes.asp</p>
DACT	Domestic Abuse Coordination Team	<p>Sheffield DACT has the responsibility for commissioning domestic abuse and sexual abuse services in Sheffield.</p> <p>The DACT is responsible for the implementation of the Sheffield Domestic and Sexual Abuse Strategy.</p> <p>The DACT works to nationally recognised good practice by working with local partners, the domestic abuse support agencies and the people who receive support, to develop services, and ensure that those who need support get it as quickly, easily and efficiently as possible.</p> <p>https://sheffielddact.org.uk/domestic-abuse/the-dact/</p>
IDVA	Independent Domestic Violence Advocates	<p>The main purpose of independent domestic violence advisors (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim’s primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans.</p> <p>https://safelives.org.uk/sites/default/files/resources/National%20definition%20of%20IDVA%20work%20FINAL.pdf</p>

<p>MARAC</p>	<p>Multi Agency Risk Assessment Conference</p>	<p>The purpose of a Multi-Agency Risk Assessment Conference (MARAC) is to reduce the risk of further assault, injury and homicide, to victims of domestic violence who have been assessed as at high risk of further abuse. The MARAC forms part of a package of measures which also includes the Independent Domestic Violence Advocacy Service, and sits within the Specialist Domestic Violence Court Programme.</p> <p>The Sheffield MARAC has been in operation since 2007 and deals with over 900 high risk cases per year. To date the MARAC has operated according to the guidance provided by CAADA, (Co-ordinated Action Against Domestic Abuse, now called Safe Lives) the charity commissioned by the Home Office to establish MARACS and train agencies. The Safe Lives website contains a comprehensive list of documents¹ covering all aspects of the running of the MARAC, and the roles and responsibilities of member agencies.</p> <p>https://sheffielddact.org.uk/domestic-abuse/wp-content/uploads/sites/3/2013/05/MARAC-Operating-Protocol-revised-February-2015.pdf</p>
<p>CMHT at Northlands</p>	<p>Community Mental Health Team (now Recovery Team)</p>	<p>The Mental Health Recovery Service (North) is based here. This service provides multi-disciplinary care to people with complex mental health issues. It delivers interventions at Step 4 and Step 5 of the NICE Stepped Care Model, statutory functions relating to the Mental Health Act and social care assessment and interventions. It aims to promote an optimum level of recovery, independence and social inclusion for each individual.</p> <p>This co-ordinated citywide service aims to provide a high level of care and support for service users and their carers when there has been a significant deterioration in a person's mental health. The emphasis is on rapid assessment, containment of crisis and risk, the delivery of comprehensive evidence-based treatment interventions and as an alternative to hospital admission.</p>

HTT	Home Treatment Team	<p>The Home Treatment Service (North) is also based at Northlands. The Home Treatment Service provides short term intensive mental health support to individuals who would otherwise require admission to hospital.</p> <p>https://www.shsc.nhs.uk/services/home-treatment-team https://www.nhs.uk/Services/clinics/Overview/DefaultView.aspx?id=46106</p>
STHFT	Sheffield Teaching Hospitals NHS Trust	<p>Sheffield Teaching Hospitals NHS Foundation Trust is one of the UK's largest, busiest and most successful NHS foundation trusts. We provide a full range of hospital and community services for people in Sheffield, as well as specialist care for patients from further afield. We manage five of Yorkshire's best known teaching hospitals.</p> <p>https://www.sth.nhs.uk/about-us</p>
LADO	Local Authority Designated Officer	<p>The Local Authority Designated Officer (LADO) provides advice, guidance and management where an allegation has been made against a person who works (paid or unpaid) with children or young people under 18 years old.</p> <p>https://www.safeguardingsheffieldchildren.org/sscb/safeguarding-information-and-resources/allegations-of-abuse-against-people-who-work-with-children</p>
VARMM	Vulnerable Adults Risk Management Model	<p>VARMM stands for Vulnerable Adults Risk Management Model and it is a formal process for assessing, recording and planning the management of risk in situations where a vulnerable and capacitated adult requires support but will not engage with agencies. This process applies in residential care and in the community.</p> <p>https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjBt-T-2pbuAhWnQhUIHTk7Dp0QFjABegQIARAC&url=http%3A%2F%2Fwww.ersab.org.uk%2FEasySiteWeb%2FGatewayLink.aspx%3FallId%3D656156&usg=AOvVaw108LjPfmZh8Msb30iy9-uF</p>

PiPoT	Managing Allegations Against People in a Position of Trust (PiPoT) Protocol	<p>A 'person in a position of trust' refers to any individual who works with adults in either a paid, voluntary or student capacity. They are entrusted to support and work with some of the most vulnerable people in Sheffield and wider communities.</p> <p>This Protocol is concerned with potential harm to adults with care and support needs, however, if the allegation is such that there is a concern that the person may also pose a risk to children then Children's Services must be informed ideally through the Local Authority Designated Office</p> <p>https://www.sheffieldasp.org.uk/assets/1/pipot_protocol_final_version_0.2.pdf (LADO).</p>
CPA	Care Programme Approach	<p>The Care Programme Approach (CPA) is a package of care for people with mental health problems.</p> <p>https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/</p>
IDAS	Independent Domestic Abuse Service	<p>IDAS is the largest specialist charity in Yorkshire supporting anyone experiencing or affected by domestic abuse or sexual violence.</p> <p>Our services include refuge accommodation, community based support, peer mentoring, group work and access to a free, confidential out of hours' helpline.</p> <p>Our teams of accredited specialist workers (IDVA's and ISVAs) support people through the criminal justice system in addition to providing emotional support and safety planning advice.</p> <p>https://www.idas.org.uk/about-us/</p>

APPENDIX 2
LIST OF MEDICAL TERMINOLOGY USED IN REPORT

Terminology	Explanation	Reference
Urosepsis, UTIs	<p>Urinary tract infections, or UTIs, are a common infection that affect more women than men. Most often, they are treated quickly and effectively with antibiotics. Unfortunately, not all UTIs are treated quickly and some aren't even identified, particularly in people who have limited or no sensation below the waist or who are unable to speak for themselves.</p> <p>Untreated urinary tract infections may spread to the kidney, causing more pain and illness. It can also cause sepsis. The term <i>urosepsis</i> is usually used to describe sepsis caused by a UTI.</p> <p>Sometimes incorrectly called blood poisoning, sepsis is the body's often deadly response to infection or injury. Sepsis kills and disables millions and requires early suspicion and rapid treatment for survival. People shouldn't die from a UTI, but if sepsis begins to take over and develops to severe sepsis and then to septic shock, this is exactly what can happen. More than half the cases of urosepsis among older adults are caused by a UTI.</p>	<p>https://www.sepsis.org/sepsisand/urinary-tract-infections/</p>
hyperkalaemia	<p>High potassium (called "hyperkalaemia") is a medical problem in which you have too much potassium in your blood. Your body needs potassium. It is an important nutrient that is found in many of the foods you eat. Potassium helps your nerves and muscles, including your heart, work the right way. But too much potassium in your blood can be dangerous. It can cause serious heart problems.</p>	<p>https://www.kidney.org/atoz/content/what-hyperkalemia</p>

<p>Wernicke's encephalopathy</p>	<p>Wernicke's encephalopathy is a neurological emergency resulting from thiamine deficiency with varied neurocognitive manifestations, typically involving mental status changes and gait and oculomotor dysfunction. The neuropsychiatric manifestations are varied but typically include alterations of consciousness, eye movement abnormalities, and gait and balance disorders.</p> <p>Unless treated as an emergency with thiamine replacement parenterally, permanent neurological injury may occur.</p>	<p>https://bestpractice.bmj.com/topics/en-gb/405</p>
<p>Macrocytosis Anaemia</p>	<p>Macrocytosis is a term used to describe red blood cells that are larger than normal. Anaemia is when you have low numbers of properly functioning red blood cells in your body. Macrocytic anaemia, then, is a condition in which your body has overly large red blood cells and not enough normal red blood cells.</p> <p>Different types of macrocytic anaemia can be classified depending on what's causing it. Most often, macrocytic anaemias are caused by a lack of vitamin B-12 and folate. Macrocytic anaemia can also signal an underlying condition.</p>	<p>https://www.healthline.com/health/macrocytic-anemia</p>