Adult N: A Safeguarding Adult Review

Kirklees Safeguarding Adults Board

Report Author: Professor Michael Preston-Shoot

1/31/22

1. Introduction

1.1. Adult N died in June 2020. He was in his 40s. No formal inquest has been held. Cause of death was acute fatty liver and chronic alcoholism.

1.2. Adult N had a longstanding dependence on alcohol. During this time he had experienced periods of homelessness, living in a car, in woodland or occasionally hotels. At times he was found living in insanitary conditions, self-neglecting, unresponsive and intoxicated. It was known that he had paid privately for detoxification and rehabilitation on several occasions but this had not been successful. He had, apparently, moved around the UK, especially the Yorkshire region, but also London and the North West. Each move would likely result in new referrals and assessments to services in that area, with impact on the building of professional relationships with new providers.

1.3. His sister has described Adult N as someone who kept himself to himself, who did not do express emotion well. On the surface he appeared to be happy but it was difficult to know how he felt on the inside. There was much he did not say about his relationships; he had become increasingly distant and isolated from friends and family.

1.4. His sister told the Independent Reviewer that Adult N had been to University and had travelled the world for work and with friends. She described him as a kind person who had been a volunteer to help people in distress.

1.5. From March 2020 Adult N was present in Kirklees. He was known to several services and efforts were made to find and then sustain him in temporary accommodation, and to treat physical ill-health repercussions of his alcohol abuse. His engagement was variable.

2. Safeguarding Adult Reviews

2.1. Kirklees Safeguarding Adults Board (KSAB) has a statutory duty[1] to arrange a Safeguarding Adult Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

2.2. KSAB has discretion[2] to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. Abuse and neglect includes self-neglect.

2.3. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[3]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.4. The referral for consideration of the case for a SAR was sent by Kirklees Adult Safeguarding Operational Team. The referral observed that there was no Care Act 2014 assessment on file and that available information related to Adult N's needs for accommodation and alcohol-related support. Mental health services had had some involvement.

2.5. Specifically, the SAR referral suggested that there had been missed opportunities to coordinate multi-disciplinary support for Adult N. it expressed concern that available self-neglect procedures had not been followed and that his self-neglect had not been identified as an adult safeguarding cause for concern.

2.6. KSAB determined that the case met the mandatory criteria for a SAR on 2nd October 2020. The KSAB SAR Sub-Group oversaw the review. The independent overview report writer met sub-group members in December 2020 to begin the work.

2.7. The following agencies, which had commissioned or provided services to Adult N when he presented in Kirklees, contributed to the review alongside the independent overview report writer.

- Independent overview report writers:
  - Michael Preston-Shoot
- KSAB Business Manager
- South West Yorkshire Partnership Foundation NHS Trust
- Kirklees Council Adult Social Care - Wellbeing
- Kirklees Housing Solution Services
- GP via Greater Huddersfield Clinical Commissioning Group
- Calderdale and Huddersfield Foundation NHS Trust

[1] Sections 44(1)-(3), Care Act 2014
[2] Section 44(4).
[3] Section 44(5), Care Act 2014

- Locala CIC Partnerships
- West Yorkshire Police
- Yorkshire Ambulance
- Choices for Health in Addiction Recovery and Treatment (CHART) Kirklees

2.8. As Adult N had also presented in North Yorkshire and also in Leeds, information was sought through the North Yorkshire and Leeds Safeguarding Adults Boards and from Leeds Teaching Hospitals NHS Trust (LTHT). Information was provided by North Yorkshire County Council, North Yorkshire Horizons[4] and Harrogate Hospital. Leeds Adults and Health Department and LTHT also provided information.

2.9. The SAR sub-group decided not to explore whether additional information was available from within other local authority areas in Yorkshire and beyond. The rationale was that the main focus was on how services within Kirklees had responded to the needs with which Adult N presented.

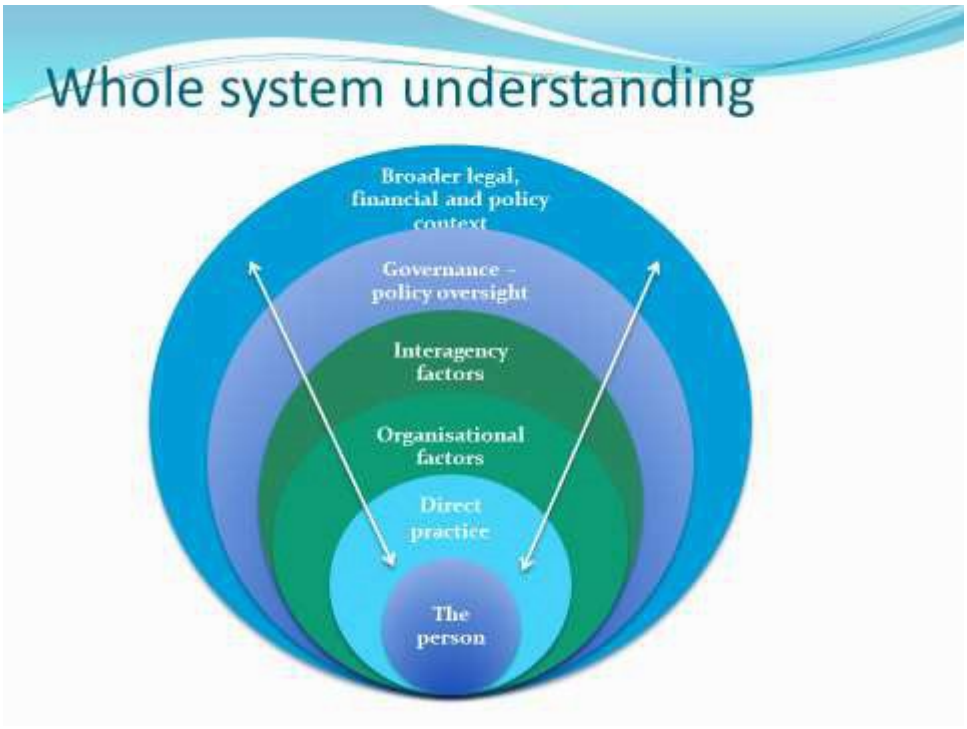
[4] A Drug and Alcohol Recovery Service.

3. Review Process

3.1. Focus

3.1.1. The case has been analysed through the lens of evidence-based learning from research and the findings of other published SARs on adults who experience homelessness[5], alcohol-dependence[6] and self-neglect[7]. Learning from good practice has also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice.

3.1.2. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



3.1.3. The overarching purpose of the review has been to learn lessons about the way in which professionals worked in partnership to support and safeguard Adult N. Specific lines of enquiry, or terms of reference, were identified as follows:

[5] Preston-Shoot, M. (2020) *Adult Safeguarding and Homelessness. A Briefing on Positive Practice*. London: LGA and ADASS.
[6] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.
[7] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

3.1.3.2. Whether services were co-ordinated in a Multi-Agency way

3.1.3.3. Whether understanding was demonstrated of each agency's roles and skills

3.1.3.4. Evidence of multi-agency communication and information sharing

3.1.3.5. Critical points in time where other actions might have resulted in different outcomes

3.1.3.6. The timeliness of interventions for Adult N and his support network

3.1.3.7. Whether the Self-Neglect policy in place at the time was implemented

3.1.3.8. Consideration of whether there is learning on a regional basis due to activity outside of the Kirklees area prior to Adult N moving to Kirklees

3.1.3.9. The SAR will also highlight areas that each agency involved can learn from to inform future practice.

3.2. Methodology

3.2.1. It was agreed that the timeframe for the review would cover the period from 1st March 2019 to the date of his death on 17th June 2020. However, information from outside this timeframe has been included when significant for understanding learning from this case.

3.2.2. Agencies provided a scoping chronology and reflective review of their involvement with Adult N within the agreed timeframe. They were advised to also include anything that they judged significant that fell outside the agreed timeframe for the review.

3.2.3. The individual chronologies were combined into an overview chronology and analysed by the independent reviewer and discussed with the sub-group. Additional questions were asked of some of the services involved to further draw out potential lessons for learning.

3.2.4. A learning event with practitioners involved in Adult N's case was held virtually, using Microsoft Teams. The outcomes of this learning event have been included in the subsequent analysis of the case.

3.2.5. Thus, a hybrid methodology has been used, designed to provide for a proportionate, fully inclusive and focused review.

3.3. Family involvement

3.3.1. The SAR referral noted Adult N's sister as his next of kin. She agreed to provide information for the review. The sub-group was informed by Adult N's sister that his mother was too unwell to participate.

3.3.2. The Independent Reviewer had a telephone conversation with Adult N's sister.

3.3.3. Adult N's sister was able to provide details about Adult N, the person, and especially about his whereabouts and what happened to him from 2016 onwards. These details are given in section 5. She also articulated her lived experience of endeavouring to support her

brother, the impact this had on her and her family, and her observations of the services that were offered. These details are also embedded in the sections that follow.

3.3.4. The Independent Reviewer is very grateful to Adult N's sister for sharing information about her brother. Her contribution filled in some missing parts of the jigsaw that was his life journey from 2016 onwards, and also shed light on Adult N, the person.

4. The Evidence-Base

4.1. Reference was made earlier (section 3.1.1) to research and findings from SARs[8] that enable a model of good practice to be constructed in relation to adults who self-neglect. The model comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect. The domains are summarised here.

4.2. For the purposes of this thematic review, evidence has been integrated into these domains regarding best practice drawn from research and SARs on multiple exclusion homelessness[9] and substance misuse.

4.3. It is recommended that direct practice with the adult is characterised by the following:

4.3.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes in line with the principle of Making Safeguarding Personal; work to build motivation with a focus on a person's fluctuating and conflicting hopes, fears and beliefs, and the barriers to change[10];

4.3.2. A combination of concerned and authoritative professional curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills; early and sustained intervention includes supporting people to engage with services, assertive outreach and maximising the opportunities that encounter brings[11];

4.3.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; failing to explore "choices" prevents deeper analysis;[12]

4.3.4. It is helpful to build up a picture of the person's history, and to address this "backstory"[13], which may include recognition of and work to address issues of loss and trauma in a

[8] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

[9] Preston-Shoot, M. (2020) *Adult Safeguarding and Homelessness. A Briefing on Positive Practice*. London: LGA and ADASS.

[10] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services.* London: National Institute for Health and Clinical Excellence.

[11] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[12] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.

[13] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

person's life experience that can underlie refusals to engage or manifest themselves in repetitive patterns;

4.3.5. Contact should be maintained rather than the case closed so that trust can be built up;

4.3.6. Comprehensive risk assessments are advised, especially in situations of service refusal and/or non-engagement, using recognised indicators to focus work on prevention and mitigation[14];

4.3.7. Where possible involvement of family and friends in assessments and care planning[15] but also, where appropriate, exploration of family dynamics, including the cared-for and care-giver relationship;

4.3.8. Thorough mental health and mental capacity assessments, which include consideration of executive capacity; assumptions should not be made about people's capacity to be in control of their own care and support[16]; nor should assumptions automatically be made that apparently unwise decisions are indicative of a lack of mental capacity;

4.3.9. Careful preparation at the point of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning;

4.3.10. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;

4.3.11. Thorough assessments, care plans and regular reviews, comprehensive enquiries into a person's rehabilitation, resettlement and support needs[17]; taking into account the negative effect of social isolation and housing status on wellbeing[18].

4.4. It is recommended that the work of the team around the adult should comprise:

4.4.1. Inter-agency communication and collaboration, working together[19], coordinated by a lead agency and key worker in the community[20] to act as the continuity and coordinator of contact, with named people to whom referrals can be made[21]; the emphasis is on integrated, whole system working, linking services to meet people's complex needs[22];

4.4.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;

[14] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[15] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[16] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[17] Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[18] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[19] Parry, I. (2014) 'Adult serious case reviews: lessons for housing providers.' *Journal of Social Welfare and Family Law*, 36 (2), 168-189. Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[20] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[21] Parry, I (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[22] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

4.4.3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;
4.4.4. Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequently implement planning and review outcomes[23];
4.4.5. Use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs associated with multiple exclusion homelessness, with specific pathways for coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital[24];
4.4.6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;
4.4.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;
4.4.8. Clear, up-to-date[25] and thorough recording of assessments, reviews and decision-making; recording should include details of unmet needs[26].

4.5. It is recommended that the organisations around the team provide:

4.5.1. Supervision and support that promote reflection and critical analysis of the approach being taken to the case, especially when working with people who are hard to engage, resistant and sometimes hostile;
4.5.2. Access to specialist legal, mental capacity, mental health and safeguarding advice;
4.5.3. Case oversight, including comprehensive commissioning and contract monitoring of service providers;
4.5.4. Agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;
4.5.5. Attention to workforce development[27] and workplace issues, such as staffing levels, organisational cultures and thresholds.

4.6. SABs:

4.6.1. Ensure that multi-agency agreements are concluded and then implemented with respect to working with high risk individuals; this will include the operation of MAPPA, MARAC, MASH[28] and other complex case or multi-agency panel arrangements, responding to anti-social behaviour, domestic abuse, offending (community safety) and vulnerability[29];

[23] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.
[24] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE.
[25] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.
[26] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.
[27] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.
[28] Multi-Agency Public Protection Arrangements (MAPPA), Multi- Agency Risk Assessment Conferences (MARAC), Multi-Agency Safeguarding Hub (MASH)
[29] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

strategic agreements and leadership are necessary for the cultural and service changes required[30];

4.6.2. Develop, disseminate and audit the impact of policies and procedures regarding self-neglect;

4.6.3. Review the interface between housing/homelessness and adult social care, mental health, and adult safeguarding, and include housing in multi-agency policies and procedures[31];

4.6.4. Establish a system to review the deaths of homeless people and/or as a result of alcohol/drug misuse;

4.6.5. Work with Community Safety Partnerships, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate governance, namely oversight of the development and review of policies, procedures and practice;

4.6.6. Provide or arrange for the provision of workshops on practice and the management of practice with adults who self-neglect.

4.7. This model enables exploration of what facilitates good practice and what acts as barriers to good practice. The analysis that follows draws on information contained within the chronologies and group discussions during the learning event. Where relevant, it also draws on available research. It follows the whole system framework for analysis presented above, beginning with the components of direct work with individuals and moving outwards to the legal, policy and financial context within which adult safeguarding and work with people who are homeless are situated.

4.8. The analysis begins, however, with a summarised chronology with accompanying commentary on good practice and on concerns about how practitioners responded to the needs and risks that Adult N presented with and how services worked collaboratively to attempt to address those needs and mitigate the risks.

4.9. Some key definitions underpin the analysis. Multiple exclusion homelessness refers to extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care.[32] Adverse experiences in childhood can include abuse and neglect, domestic violence, poverty and parental mental illness or substance misuse.[33] For many of those who are rough sleeping, homelessness is a long-term experience and associated with tri-morbidity (impairments arising from a combination of mental ill-health, physical ill-health and drug and/or alcohol misuse) and premature mortality.[34]

4.10. Care and support needs arise from or are related to physical or mental impairment or illness. This can include conditions as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury (Care and Support (EligibilityCriteria) Regulations 2014.

[30] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[31] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[32] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

[33] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England.

[34] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

5. Case Chronology[35] and Initial Commentary

5.1. Some information is available prior to Adult N's first recorded contact with services in Kirklees in early March 2020. Forward Leeds has confirmed that Adult N participated in structured treatment sessions for alcohol use between September 2015 and June 2016, at which point he dropped out. West Yorkshire Police (WYP) have a record of Adult N as a missing person on 22nd May 2016. He had recently left a rehabilitation facility and begun to drink again. He had also recently lost his job. He was found in a street covered in vomit and taken to hospital in Leeds.

5.2. His sister recalled that he had spent some time in a rehabilitation facility in Barnsley. She recalled that he had drunk whilst there. He had returned to Leeds. This may be the facility referenced above.

5.3. On 23rd May 2016 Leeds Teaching Hospitals NHS Trust (LTHT) has recorded that Adult N attended the Emergency Department at St. James Hospital. He was under the influence of alcohol. He self-referred but gave only a limited history. When sober and orientated, he was discharge after review of blood test results. This was to become a repeating pattern.

5.4. On 24th May 2016 Adult N presented at Leeds Housing Options requesting emergency temporary accommodation for the night. He said that he had left rehabilitation on 18th May. Information gathered by Housing Options staff included that he had spent all his money on alcohol and that his drinking had escalated after he had lost his job. It is recorded that he was known to Forward Leeds and was being referred to St. Anne's for support. As he was intoxicated he was advised that he could not be accommodated. On 3rd June he advised the service that he no longer required assistance. His case was formally closed on 8th June. There is no further record of any housing application from Adult N in Leeds.

5.5. Indeed, Adult N was referred to St Anne's Services in Leeds on 27th May 2016 by Forward Leeds Hospital Team. He was triaged on 10th June and admitted for detox on 21st June. He was discharged on 25th June.

5.6. On 10th August Adult N attended an eye clinic outpatient appointment at LTHT. He was suffering with a thin retina and bilateral flashing lights. He was under the care of the Ophthalmologist Team. No concerns were noted, he was reassured and advice was given.

5.7. On 23rd October 2016 he once again self-referred to the Emergency Department at St. James Hospital in Leeds. He was reporting loss of consciousness and possible fits. Once again, as a result of his intoxication, it was possible only to obtain a limited history. Blood screen results were within normal parameters. He was discharged. Commentary: a repetitive pattern is emerging but the approach taken on this presentation was the same as that in May.

5.8. Adult N's movements are not entirely clear for much of 2016 and for all of 2017. His sister recalled that for around eight months Adult N had lived with her and her family, being sober for some of this time. He had then secured employment and moved to Sheffield. His alcohol-dependence increased and she recalled that he was known to both major hospitals in Sheffield and to an agency working with people misusing substances. She thought that supported accommodation had been considered at this time and remembered one occasion when it had proved necessary for emergency services to break into his flat. There were times

[35] The case chronology has been updated since the learning event.

when he lost movement in his body because of the effect of alcohol consumption, or severely injured himself, including on one occasion a fractured skull.

5.9. Precise timings remain unclear. His sister recalled that he paid privately for rehabilitation at clinics in London and in Blackpool. She was unable to be precise about dates but it seems likely that at least one of these admissions would have been in 2017; another possibly in 2018. He also went abroad for rehabilitation and did well for a time but it is unclear when this was. Nonetheless, the picture is one of continued alcohol-dependence, which his sister believes was a coping response "to forget everything." He lost most of his possessions during this time.

5.10. On 21st December 2017 Adult N was assessed by the Basement project in Huddersfield following a referral from On-Track Kirklees Alcohol Services. The purpose of the referral was for support due to his on-going alcohol misuse. He was assessed as suitable for a pre-recovery group but did not attend any of the January 2018 sessions. His case for group work was closed on 18th January 2018. However, Adult N is recorded as having used the breakfast club, peer support groups and mutual aid meetings periodically. He sought advice on 28th December 2017 and attended for food on 11th January 2018, 8th March, 22nd March and 5th April. There was no further contact until June 2019.

5.11. By May 2018 Adult N was once again in Leeds. On 20th May he presented at the Emergency Department of Leeds General Infirmary. He was under the influence of alcohol. Once again, only a limited history was obtained because of his intoxication. When sober he was discharged following review of blood test results. The following day the pattern repeated but this time at the Emergency Department of St. James Hospital. **Commentary:** no other action seems to have been taken by the Hospitals.

5.12. The next day, 22nd May, the pattern again repeated, this time at Leeds General Infirmary. On this occasion he was admitted as he was clinically dehydrated and had deranged bloods; he was treated with intravenous fluids. On 25th May he requested to self-discharge. He was advised to stay for electrolytes checking but would not wait for bloods/medication and signed a self-discharge against medical advice form. He understood the risks of life threatening arrhythmia and was assessed to have capacity. **Commentary:** assessment of mental capacity was good practice. No adult safeguarding concern was referred, however, and it is not clear how his apparent dependence on alcohol was factored into whether he could use or weigh information about treatment.

5.13. A few hours later on the day he was discharged by Leeds General Infirmary, he presented at the Emergency Department of St. James Hospital. He complained of chest pain but an ECG proved normal. His blood screen was also normal. He declined admission and was discharged with advice. The following day, 26th May, Adult N returned to the same Emergency Department, complaining of chest pains, anxiety and alcohol withdrawal. His ECG and blood screens were normal. Diagnosis was a panic attack and anxiety. **Commentary:** the repeating pattern does not appear to have prompted an adult safeguarding concern.

5.14. On 10th June Adult N once again presented at St. James Hospital Emergency Department. He was brought after he had been found by his landlady intoxicated. He had reduced consciousness levels but denied chest pain. He was put on intravenous fluids and referral to Forward Leeds[36] was made. He was assessed for possible paracetamol overdose.

[36] A drug and alcohol service provider.

All tests and observations were normal and he was discharged. Forward Leeds In-Reach Team saw Adult N in hospital. He declined offers of referral and treatment. **Commentary:** there has been little change in the approach taken by LTHT staff, despite the repeating presentations. A more assertive approach with Adult N regarding his alcohol misuse does not appear to have been considered, to attempt motivational work.

5.15. On 14th June 2018 WYP recorded that Adult N appeared to be living in a car in Leeds. He was heavily intoxicated and was taken by Ambulance to St James Hospital in Leeds. He presented with alcohol intoxication and reduced conscious levels. Once again he was put on intravenous fluids and referral to Forward Leeds was mentioned. All tests and observations were normal and he was discharged. **Commentary:** no information is available as to whether an adult safeguarding concern was referred by WYP or whether his homelessness was also the subject of referral. There is no mention of an actual referral to Forward Leeds.

5.16. However, Forward Leeds has commented that Adult N self-referred in September 2018. He had been abstinent and was wanting support with coping mechanisms to avoid relapse. He attended groups and drop-in sessions until sometime in October 2018 when he started paid employment. He did not return to Forward Leeds thereafter.

5.17. Two days later he presented at the same Emergency Department with alcohol intoxication. He denied experiencing chest pains. All tests and observations were normal and he was discharged when fully awake and medically fit. **Commentary:** this is his last recorded presentation at LTHT until March 2019. There has been no change in how staff responded to his repetitive presentations.

5.18. On 14th March 2019 Adult N presented twice at Leeds General Infirmary Emergency Department, firstly early morning and subsequently at lunchtime. On the first presentation he complained of tingling in his fingers and ringing in his ears. He also complained of blurred vision in both eyes. No weakness and no neurological concerns were noted in the Department and he was advised to consult his GP for a possible referral to ENT. On the second presentation he complained of anxiety and generalised weakness, wondering if he was experiencing a stroke. ECG was carried out; no collapses were recorded or family history of sudden death, but a family history of cardiac problems was noted. Given the history, patient anxiety and history of alcohol misuse, a bedside echocardiogram was undertaken by cardiology for alcoholic dilated cardiomyopathy. No abnormalities were observed but his GP was to be advised to refer Adult N to the inherited cardiac clinic.

5.19. On 28th May 2019 WYP reported that Adult N was found intoxicated and dishevelled in a flat in a shared house. A call had been received from his mother. Information received indicated that he had been sober for 14 months until recently. WYP referred Adult N to Leeds Adults and Health (Adult Social Care). **Commentary:** the referral to Adult Social Care was good practice.

5.20. Leeds Adults and Health recorded the referral from WYP on 29th May as for adult safeguarding, based on concern expressed by Adult N's mother with respect to his health and alcohol misuse. He had apparently requested help with his drinking when spoken to by WYP Officers. The outcome of the referral appears to have been attendance at a rehabilitation facility in Manchester with the support of his then GP. **Commentary:** there does not appear to have been an assessment of his care and support needs.

5.21. Shortly after this episode in Leeds, Adult N was back in Kirklees. He accessed recovery support from the Basement Project on 12th June, with further recorded contact on 17th and 18th June, 15th July and 5th August. Once again, he then disappeared until renewing contact in early March 2020.

5.22. However, whilst in Kirklees in June, he also attended an Ophthalmology outpatient appointment in Leeds on 19th June. No concerns with his eyes were noted. He was discharged from further follow up.

5.23. On 2nd July 2019 Adult N's mother reported him missing to WYP. He had recently left a rehabilitation facility in Blackpool and was attending the Basement project in Huddersfield. His mother reported that he was an alcoholic and had previously suffered a fractured skull. Police found Adult N at an address; he was safe and well.

5.24. On 28th August Adult N attended a cardiac outpatient appointment in Leeds. Various tests and assessment were conducted but nothing abnormal was detected. He was discharged.

5.25. The focus then begins to switch to North Yorkshire. On 9th and 10th September, he attended Harrogate Hospital Emergency Department intoxicated and, on the first occasion, incontinent. He was discharged. Harrogate Borough Council received a telephone call on 10th September from a landlady who had offered Adult N a room in her house, to the effect that Adult N had to leave. She was concerned about his drinking and the impact this was having on herself and family. She was advised that he should self-refer but he did not do so. On 13th September he presented again at Harrogate Hospital, intoxicated and with a minor head injury. He declined admission.

5.26. On 14th September Adult N was brought by Ambulance to St. James Emergency Department, having been found in a collapsed state with reduced consciousness levels. He had been sitting on some steps with other people in Leeds city centre. He was intoxicated. Outreach workers were handing out food to homeless people and witnessed Adult N to slump over and have a 4 minute seizure. They placed the patient into the recovery position. No trauma and no head injury were witnessed. Following various blood tests and clinical examination, he was assessed as medically fit and was discharged with advice.

5.27. The following day, 15th September, he was again taken by Ambulance to the Emergency Department of St James Hospital. He had been found staggering around Leeds city centre. He was conscious and alert but appeared intoxicated, stating that he had been drinking all night. As he regained sobriety and following various blood tests and clinical examination Adult N was assessed as medically fit and was discharged with advice. The following day, 16th September, he presented first at Leeds General Infirmary Emergency Department with alcohol intoxication but did not wait to be seen. One hour later he presented at St James Hospital Emergency Department with alcohol intoxication. He was put on intravenous fluids. He denied chest pains and following examination was discharged with advice. **Commentary:** neither the Ambulance Service nor LTHT referred Adult N as a safeguarding concern. No referral to an alcohol service provider appears to have been made.

5.28. The following day, 17th September, Adult N attended St James Emergency Department with alcohol intoxication. For a time he could not be identified because of his reduced consciousness level and the Hospital contacted WYP for assistance. He was eventually able to confirm his identity and he was admitted for intravenous fluid treatment,

CT scan and further assessment. On 19th September he self-discharged against medical advice. His GP was informed.

5.29. On 20th September he presented twice at Harrogate Hospital Emergency Department. On the first occasion he did not wait for results, having complained of collapse. He attended with two bottles of vodka. On the second occasion, half an hour later, he was discharged. The following day he presented again, intoxicated. He was encouraged to take fluids and was discharged. **Commentary:** as with his presentations at LTHT, a repeating pattern regarding alcohol misuse was emerging. However, no adult safeguarding concern was referred and no other intervention has been recorded.

5.30. On 26th September 2019 Yorkshire Ambulance Service (YAS) found Adult N asleep in his car in Harrogate, North Yorkshire. He was covered in vomit. His car was covered in vomit and urine. He had been staying in hotels but had been asked to leave because of his alcohol-dependence and presentation. He reported having been in hospital several times in recent weeks. An adult safeguarding concern was referred by YAS because of self-neglect and support for Adult N was requested. He was homeless. He was admitted by Harrogate Hospital and discharged on 28th September. **Commentary:** the referral by YAS of an adult safeguarding concern was good practice. The Hospital has not recorded whether Adult N was referred under the provisions of the Homelessness Reduction Act 2017. The Hospital did not refer an adult safeguarding concern.

5.31. No further action was taken under safeguarding. Adult N was spoken to by a Senior Practitioner in Health and Adult Services. Adult N stated that he was no longer living in his car and had funds for a hotel room until he could access more permanent accommodation. He stated that he had attended North Yorkshire Horizons to address his drinking[37] and was on the waiting list. It was concluded that he was addressing the issues that had triggered the adult safeguarding concern and was capable of sourcing housing and support for himself. He did not consider that further action was needed. **Commentary:** on the basis of this one encounter, that assessment would appear reasonable. Judged against the history, however, if that had been known, the assessment appears over-optimistic. The difficulty of triangulating self-report with what is known by other agencies, especially when this information is held in another local authority area, is a feature of this case.

5.32. A mental health assessment was completed on 27th September whilst Adult N was in hospital. The record notes that his family had reported him as missing but that he did not want to make contact as they would not understand and would become annoyed. The referral appears to have been made because he had expressed suicidal thoughts when at the hospital on 20th September. He denied suicidal thoughts during the assessment. He was not willing to engage in a full assessment or to discuss his history. He was reportedly embarrassed about having been incontinent. The Hospital had disposed of his clothes because of their condition. **Commentary:** the record of the mental health assessment is confusing. At one point it records that Adult N wished to address his drinking and consequently he was signposted to alcohol addiction services. At another point, however, it records that he was unwilling to engage with either mental health or alcohol addiction services. Where the record is consistent is in recording that there was no evidence of mental illness and no role therefore for secondary mental health services. His case was therefore closed. Three questions arise. Firstly, was it reasonable to close his case after just one

[37] North Yorkshire Horizons have recorded that he self-referred for alcohol-related support on 27th September 2019.

contact rather than attempt to establish a relationship that might then pave the way for discussion about how he was now presenting and what his history had been? Secondly, is it not reasonable to consider whether his alcohol-dependence was evidence of impulse control disorder and/or of mental distress? Thirdly, given his history, was simply signposting him to services a sufficient response? It would have been appropriate to have discussed with Adult N accompanying him to the services that had been signposted, as a way of making every contact count.

5.33. On 3rd October Adult N completed a triage assessment with North Yorkshire Horizons. On 4th October he attended a recovery support group.

5.34. On 17th October Adult N again presented at the Emergency Department of Harrogate Hospital. He had been drinking for days, had no food, and was covered in urine and faeces. He was admitted and discharged on 24th October. The pattern repeated on 1st November when Adult N was found in his car. He was admitted and discharged on 3rd November. On 5th November he presented again, intoxicated and covered in urine and faeces, but left before treatment. On 7th November he was again found intoxicated in his car and was admitted through the Emergency Department, being discharged the following day. **Commentary:** no adult safeguarding concern was referred and no other intervention has been recorded.

5.35. On 25th October Adult N attended a recovery support group but on 28th October he failed to attend for a comprehensive assessment. Attempts to contact him to rearrange were unsuccessful.

5.36. On 18th, 19th and 20th November 2019, Adult N was seen in the Emergency Department of Harrogate Hospital. He was admitted on 19th and discharged on 20th. A referral to Health and Adult Services was made. As he made no response to attempts by a Social Care Coordinator to make contact, he was advised to self-refer. He did not do so. **Commentary:** the referral to Health and Adult Services was good practice. Efforts were made to contact Adult N following the referral but it is questionable whether there was sufficient in-reach and outreach in order to complete a care and support assessment.

5.37. On 23rd November he presented again at the Emergency Department in Harrogate, intoxicated and incontinent. He was discharged. The following day he presented again, having been found unresponsive and hypothermic. He was advised to attend Horizons and was discharged. **Commentary:** the Hospital did not follow up its referral to Health and Adult Services, nor was an adult safeguarding concern referred.

5.38. On 27th November he presented again at the Emergency Department in Harrogate. He was intoxicated and covered in urine and faeces. He was admitted and discharged on 3rd December. Records held by the Emergency Department have noted that Horizons had made contact on 4th December and Adult N had attended for an assessment. Indeed, Adult N had renewed contact with Horizons on 2nd December and a triage assessment was completed on 4th. He reported to have been drinking up to 3 bottles of vodka daily. On 6th December Horizons completed a comprehensive assessment, at which point Adult N was stating that he had been abstinent for one week following detox in hospital.

5.39. On 12th December he failed to attend Horizons for a health and wellbeing assessment with a Nurse. The following day he did attend a structured support session and a recovery support group meeting, and was reporting continued abstinence. On 17th

December he attended a health and wellbeing assessment with a Nurse followed by a 1:1 support session with a Recovery Worker and the recovery group.

5.40. Before 23rd December Adult N had been in contact with Harrogate Homeless Project in December 2019 and on that date the project spoke directly to a Housing Options Private Sector Officer and asked him to call Adult N. Voicemails were left for Adult N to ring him back but it appears that he did not do so.

5.41. On 25th December he presented again at the Emergency Department. He had open blisters on both feet, having been walking bare foot. Urine burns were also observed. He was discharged. On 30th December he presented again, complaining of vomiting. He was admitted and discharged on 14th January 2020. North Yorkshire Horizons have recorded that the Hospital informed the service on 2nd January that Adult N had been admitted. The Hospital contacted Horizons on 13th to inform the service of his imminent discharge.

5.42. Between 10th and 14th January 2020 there was contact between Harrogate Hospital, Harrogate Borough Council Housing Options and North Yorkshire Health and Adult Services. Adult N was being discharged from hospital with bandaged legs as a result of sepsis. He had been residing in a hotel where there were concerns about the stench coming from his room but also spending nights in his car, homeless. He would have been given temporary accommodation, had he or the hospital made further contact. A Home from Hospital service was planned to support him with shopping until his feet healed. He was assessed as having no other eligible needs and his case was closed.

5.43. Horizons attempted unsuccessfully to contact Adult N on 15th and 20th January. On 21st January Horizons recorded that Adult N had been discussed at Safer Communities but no other record has been located to confirm that his case was discussed.

5.44. On 20th January he attended the Emergency Department in Harrogate[38]. Cellulitis to his buttocks and alcohol withdrawal syndrome were recorded. He was admitted, being discharged on 28th January[39]. On 30th January he presented again, intoxicated and incontinent. He was admitted and discharged the following day. The pattern repeated on 1st February, again intoxicated and unresponsive. He was admitted and discharged the following day. On 4th February Harrogate Hospital advised Horizons of his discharge. His last recorded attendance at the Emergency Department in Harrogate was on 5th February. He was admitted as a result of excessive use of alcohol and discharged two days later. Harrogate Hospital informed Horizons of this admission and a worker from Horizons visited him on the ward. After his discharge on 7th, Adult N dropped in to Horizons and an appointment was made. **Commentary:** each episode appears to have been treated individually rather than being seen as part of a pattern for which a longer-term, multi-agency risk mitigation plan was required. Nonetheless, information-sharing by the Hospital with Horizons was good practice, as was the visit by Horizons to Adult N on the ward.

5.45. YAS have recorded three further contacts with Adult N in Harrogate, on 30th January, 1st February and 5th February 2020. On the first occasion he was intoxicated and unresponsive on the street. On the other occasions he was in hotels, also intoxicated and relatively unresponsive. On the last occasion he is also recorded as having urinated himself.

[38] The Independent Reviewer has been informed that this was his 19th attendance.

[39] On 24th January Adult N informed Horizons that he had been admitted to hospital.

Commentary: it is unclear what action was taken on these occasions. No adult safeguarding concerns were referred.

5.46. Following unsuccessful attempts by Horizons to contact Adult N on 10th, 14th and 20th February, his case was closed due to non-engagement. The last contact occurred on 6th March when Adult N telephoned to say that he was okay and staying with his mother. He was advised he could re-refer at any time.

5.47. By early March 2020 Adult N was back in Kirklees. On 7th March he resumed contact with the Basement Project, with recorded contact also occurring on 10th, 12th, 13th, 16th and 17th March for food, advice, and recovery support. Thereafter he does not appear to have contacted the Basement project again. On 9th March he registered with a GP practice and on 10th March had the first of four telephone consultations, this time for a foot blister/toe infection.

5.48. His first appointment with Housing Solutions came on 12th March to discuss his accommodation needs. He had also made contact with Fusion Housing. Their involvement spanned 9th March to 11th May. Their records indicate that Adult N self-referred to their accommodation service, having been sleeping on the floor at his mother's address. He mentioned that he had been living in Harrogate but had been unable to access accommodation there as he had no local connection. He said his family lived in Kirklees and he did not disclose any history of alcohol misuse. The assessment took place on 13th March. He said that he had spent four months in private sector accommodation but left to return to Huddersfield following issues with an alcoholic landlady. He also mentioned having had a number of tenancies for short periods in the private sector and said that he had generally moved to find employment. He claimed to be a 'social drinker.' He said that he was recovering from cellulitis and sepsis, and that he had several blisters on the ball of his foot as a consequence of cellulitis. He disclosed suffering from anxiety and depression with Sertraline[40] and Flucloxacillin[41] medication. He was receiving Universal Credit.

5.49. Fusion Housing had no further recorded contact either with Adult N until the 6th April 2020. **Commentary:** Fusion Housing have commented that this is not the expected standard of service delivery. It was caused by the national restrictions imposed and the relocation of staff to home working within a very short time scale. At this time, the focus of the accommodation services was putting safe practices and procedures in place for all the clients currently housed with Fusion Housing (around 250 at the time) to minimise the risks associated with COVID 19 and ensure that the service could still offer intensive housing management services to everyone. Particular attention was paid to the risks associated with those who lived in shared accommodation. As a result, focus was diverted away from applicants and therefore there was a delay in continuing to process and finalise assessments that had already taken place.

5.50. Fusion Housing was made aware by the Housing Solutions Team at the Council that Adult N had been in hospital, but there are no records at Fusion Housing detailing why he had been admitted to hospital. Information was exchanged between the two services, including that Adult N had been asked to leave Bed and Breakfast (B&B) accommodation due to concerns about his behaviour and his hygiene. This led Fusion Housing on 8th April to decline to offer Adult N accommodation as no self-contained accommodation was available

[40] Treatment for depression and anxiety disorders.

[41] Treatment for bacterial infections.

at the time. The only means of informing Adult N was by text message. He did not respond until 5th May when he left a message indicating that he was awaiting a decision. He was not spoken to until 11th May, again as a result of disruption to services caused by the pandemic. He was informed that there were only rooms in shared houses with shared bathroom facilities available and these were not considered suitable for Adult N's needs.

5.51. On 27th March Calderdale and Huddersfield NHS Foundation Trust (CHFT) recorded Adult N's first presentation. He was found wandering round the hospital appearing intoxicated. He was treated and an Occupational Therapist assessed him as safe for discharge, describing that he lived alone and managed independently. He had 2 bottles of gin and money in his possession. A referral for podiatry was made. A discharge letter was sent to his GP practice[42] identifying one-day admission for alcohol withdrawal.

5.52. On 30th March YAS conveyed Adult N to hospital, having found him in a car when alerted by a member of the public. He was visibly shaking but would not allow assessment by the Ambulance crew. There were empty bottles of alcohol visible. At CHFT he was assessed as having experienced an alcohol-related seizure. He was unkempt. He had excoriated buttocks and a foot blister. Advice was given about excessive alcohol consumption. He was not confused. He was admitted from the Emergency Department because of the need for Occupational Therapy/Physiotherapy assessment and for input from Adult Social Care regarding homelessness. He had been sleeping in his car. CHFT recorded difficulty in obtaining a clear history, including where he had been living – possibly with his mother but also in what he described as a young professionals' property and using toilet and washing facilities in a local McDonalds. He declined support, suggesting that he had sufficient money and could look after himself.

5.53. He was discharged the following day. A discharge letter was sent to his GP, detailing admission with social problems due to alcohol-dependence. **Commentary:** YAS do not appear to have referred an adult safeguarding concern when Adult N was found unkempt in his car. CHFT do not appear to have referred Adult N as a safeguarding concern. Nor did CHFT refer Adult N under the Homelessness Reduction Act 2017 although it was known that he had been living in his car. Advice was given regarding excessive alcohol consumption, and contacting his GP and liaison services. He denied that he had an alcohol problem, admitting only to occasional binge drinking. His housing situation was discussed, with Adult N stating that he had been staying with his mother but also had a rented room in a property occupied by young professionals. He had, however, been sleeping in his car for two days because he could not lock it, having lost the key, and there were valuables within it.

5.54. CHFT Discharge Team for complex cases, and the Hospital Avoidance Team were involved at this point. Adult N was reluctant to discuss his complex social history. He wanted to be discharged once his feet had been assessed. He did state that he had lost his job in Harrogate. He did not feel that he required help from Adult Social Care. He had a large sum of money with him, which he said he could use to access B&B if necessary.

5.55. On 31st March Locala podiatry services received a referral from the podiatry service in CHFT for a foot ulcer on the bottom of his foot. The referral said that Adult N could attend clinic. An appointment was made for 2/4/2020, which he did not attend as he was in hospital.

[42] Adult N had given an address and there was a GP registration for that address.

5.56. Between 2nd and 6th April the pattern was repeated. Adult N was found in his car by WYP. His clothes were soaked wet; there was a smell of alcohol. He was admitted to CHFT with a probable alcohol-related seizure and possible abscess on the sole of his right foot. He stated that he was living in his car to avoid staying with his mother during the coronavirus pandemic. He gave a similar reason for not wishing to return to a room in a rented property. CHFT discharge team contacted Housing Solutions and, although Adult N could have been regarded as having made himself intentionally homeless, temporary accommodations was found at a local hotel. CHFT sent a discharge letter to the GP practice, recording admission for alcohol withdrawal. **Commentary:** liaison between the CHFT discharge team and Housing Solutions was good practice, as was the allocation of temporary accommodation. No adult safeguarding referral for self-neglect appears to have been sent. No referral as a response to his alcohol misuse appears to have been considered.

5.57. The first involvement with the Kirklees Emergency Duty Service (EDT) occurred on 10th April when the hotel passed on information that he was being evicted because of excessive drinking and defaecating his room. **Commentary:** no follow-up referrals or action occurred in response to this information.

5.58. On 11th April YAS found Adult N in his car in Halifax, unresponsive and making "jerky" movements. He was dressed in hospital pyjamas and barefoot, soaked in urine and covered with faeces. Five empty pink gin bottles were observed. YAS records noted that Adult N was choosing not to use arranged accommodation, having previously been treated for sepsis and not wanting to infect anyone else. YAS records also included the observation that Adult N lacked capacity at this time due to his intoxication. **Commentary:** a formal mental capacity assessment would have had to wait until the effect of intoxication had subsided. No adult safeguarding concern appears to have been referred by YAS. WYP has commented that there was a missed opportunity by the Police to refer Adult N to Adult Social Care (ASC) at this time.

5.59. YAS transported Adult N to CHFT. Contact was made with EDT for support. He was unwilling to return to his mother's address because of her vulnerability with respect to the COVID-19 pandemic. He was discharged back to the hotel that had previously notified EDT of his eviction. He had money to pay for a taxi and a hotel room. It was expected that ASC would contact him the next day. The Mental Health Liaison Team (MHLT) were contacted. A Mental Health Liaison practitioner reviewed the notes and these indicated that there was a history of alcohol dependence since 2014 and several inpatient admissions for detox treatment. The notes indicated also that Adult N had not taken his anti-depressant medication consistently. The practitioner provided information to the Charge Nurse to give to Adult N regarding substance misuse. The Charge Nurse and Mental Health Liaison practitioner agreed that MHLT assessment was not required.

5.60. **Commentary:** liaison between practitioners was good practice. However, a repeating pattern with respect to alcohol-dependence and self-neglect was not addressed through a plan for in-reach or outreach assessment. There was evidence of a history of mental health issues but no assessment for depression was planned. No referral for an adult safeguarding enquiry or for assessment of his care and support needs has been sent to ASC.

5.61. The repetitive pattern continued. On 13th April YAS found Adult N in his car as a result of contact from a Police Community Support Officer. This was the third contact in three days by YAS with Adult N. He was covered in urine and vomit. His car was soaked with

spilt alcohol. He was taken to CHFT with his consent. **Commentary:** no adult safeguarding concern was referred by YAS.

5.62. Calderdale Community Protection Team has provided further information about events on 13th April. Neighbours had complained about an abandoned vehicle. Adult N appeared to be living in the car. Community Safety Wardens visited and gave notice to vacate, Adult N had been very intoxicated and did not engage so the notice was attached to the car windscreen. The Wardens discussed the situation with a Rough Sleeper Navigator and liaised with local residents. Later in the day Wardens paid another visit to the site to engage with Adult N. His health appeared to have deteriorated; he was less responsive and less alert. The Wardens called an ambulance and passed information on to Calderdale EDT. Night shift wardens attended CHFT and were informed by Nursing Staff that Adult N would be discharged to the hotel at which he had a room in Kirklees. It was noted that this sequence of hospital admission and discharge to the hotel, with Adult N returning to his car, had happened three times previously. **Commentary:** calling the ambulance and information-sharing was good practice. No adult safeguarding concern was referred, however.

5.63. At CHFT Adult N said he did not want to come in because he had no medical concern. He was intoxicated. He was worried that he could not live with his mother because of her need to shield from COVID-19. Staff assisted him to shower due to his poor hygiene and spoiled clothes. As he had no clean clothes, some were provided by hospital staff. He refused food and was very thirsty. He had no money on him. Contact was made with ASC as a result of which he was discharged back to the same hotel, for which CHFT arranged a taxi, with an expectation of ASC contact to follow. A discharge letter was sent by CHFT to the GP practice noting attendance for alcohol intoxication.

5.64. The following day, 14th April, Adult N fell whilst intoxicated in his mother's doorway and sustained abrasion to his forehead and cuts to his legs. He was still living in a car and using it as a toilet. He is recorded as reluctant to stop his alcohol intake. He was admitted to CHFT. Contact was made with a Rough Sleeping Navigator. EDT in Calderdale was contacted for accommodation and the Navigator's number given to him as his car had to be moved due to it being in an area where there are children and it being full of faeces and medication. The hotel where he had been accommodated would not accept him as he has been leaving faeces in the room. Kirklees EDT and Gateway to Care (GTC) were contacted and discharge arranged to a different hotel. Adult N was advised about alcohol reduction. The expectation was that Housing Solutions would contact him the following day at the hotel.

5.65. Also on 14th April, South West Yorkshire Partnership Foundation Trust (SWYPFT) has a recorded entry from the Single Point of Access (SWYPFT) to note that there had been a telephone call from Horton Housing. The worker from Horton Housing said that they were at the side of the Adult N's car but that he could not be located. Horton Housing indicated that they had become involved as it has been noted that the service user was 'rough sleeping'. The worker was enquiring if there were any mental health concerns for Adult N. Information was exchanged and the record notes that there was no further action by SPA required.

5.66. Calderdale Community Protection Team has provided further information for the events of 14th and 15th April. Community Wardens made additional visits to the location of the car on 14th and 15th April but Adult N was not there. Neighbours had not seen him. Tape was added to the car to indicate that services were aware of it. The Rough Sleeper Navigator had visited the site and observed through an open car window faeces, vomit, packaged

prescribed medication and cash on display. Community Safety Wardens arranged for the removal of the car on 15th April. Adult N reclaimed it on 23rd April.

5.67. **Commentary:** liaison between agencies and services was good practice. Temporary accommodation was in place for Adult N, to meet his most immediate need. To date, however, no referral appears to have been made for an ASC care and support assessment and it is difficult to see a plan that would attempt to mitigate risks arising from self-neglect and alcohol-dependence. No multi-agency risk management meeting has been suggested. No adult safeguarding concern appears to have been referred.

5.68. On 15th April WYP and EDT were unable to make contact with each other. The following day the hotel reported criminal damage to WYP. Adult N had asked to extend the rental of his room and this had been refused. He was refusing to leave his room and had urinated on the bed. An Ambulance was requested. Adult N was difficult to rouse and was unsteady on his feet, likely due to intoxication. The Ambulance transported him to hospital. A criminal damage offence was recorded, with no further action due to prosecution not being in the public interest. Adult N did not remain at CHFT but left for an unknown destination.

5.69. Later on the day, 16th April, WYP and YAS located Adult N at Halifax train station. Adult N had a fractured right rib and a graze to his head, which he reported he did several days ago. He was in possession of 2 bottles of vodka. He refused to travel and declined any care from the ambulance crew, who left Adult N in the care of Police who were trying to find a place of safety for him. Calderdale EDT was contacted by WYP. Kirklees Intensive Home Based Treatment Team (KIHBTT) also received a telephone call from WYP who identified that they were with Adult N at the train station. The Police informed KIHBTT that Adult N had stated that he had plans to go to Manchester Airport. The Police stated that Adult N denied any self-harm and suicidal thoughts, it was noted that he appeared intoxicated and there was alcohol in his bag. KIHBTT informed the Police that he had temporary accommodation at the original hotel that had first accommodated him temporarily in Kirklees. Recorded notes identify no further action for KIHBTT. **Commentary:** liaison between WYP and KIHBTT was good practice. However, as yet there has been no formal assessment by an alcohol-related service since services in Kirklees first became aware of Adult N at the beginning of March. Each crisis is being responded to with an attempt to secure temporary accommodation but it is difficult to discern a plan to sustain him in that accommodation and to address his wider needs and the risks associated with self-neglect, homelessness and alcohol-dependence.

5.70. On 17th April, Housing Solutions have recorded that an adult at risk safeguarding form was submitted. **Commentary:** this appears to be recounting information received from Calderdale Council's Community Protection Team concerning Police involvement the previous day. Housing Solutions are unable to state whether an adult safeguarding concern was referred at this time and, if so, by whom. Adult Social Care has no record that an adult safeguard concern was received at this time.

5.71. On 18th April 2020 Adult N presented for the final time at Leeds General Infirmary Emergency Department. He arrived by ambulance in a presenting collapsed state with reduced consciousness levels after being found in the street in Leeds city centre. He had a wound to his face, with intoxication of alcohol. Oxygen and intravenous fluids were given. He was admitted overnight for full observation and review. He regained sobriety and following various blood tests and clinical examination, he was assessed as medically fit. He

was discharged with advice. **Commentary:** once again, no referrals appear to have been made.

5.72. On 19th April CHFT recorded that Adult N had been found in woodlands smelling of alcohol. He had 4 layers of clothing on including a hospital gown. When alert he was discharged, intending to walk to his mother's address in Kirklees even though he felt that she might not want him there in case he had another alcohol-related seizure.

5.73. On 21st April Adult N attended Huddersfield Royal Infirmary following an alcohol-related seizure. Again, he wanted to walk to his mother's address, expressing the same anxiety about staying there as two-days previously. He was discharged. A discharge letter was sent to the GP, again recording alcohol-related seizure.

5.74. On 23rd April Adult N contacted his GP for a telephone consultation as he stated he had been told by CHFT Emergency Department that he could request his GP to prescribe medications for alcohol withdrawal – this information was incorrect. His GP advised Adult N that GP's in Kirklees cannot deliver alcohol detox medication and that he needed to contact alcohol services for this. His GP accessed a website and gave Adult N a contact number and advised him to call them. His GP also recorded that Adult N was living temporarily with his mother so the GP arranged for his other repeat medications to go to his mother's address. **Commentary:** the wisdom is debatable of relying on individuals who are homeless and self-neglecting to initiate contact without support or assertive outreach with alcohol-related services. However, not all the detail was known by the GP at this point of his previous history, which highlights the importance of information-sharing and access to historical records; it also highlights the importance of multi-agency meetings, including the involvement of practitioners from outside Kirklees, at which relevant information can be collated and shared.

5.75. On 4th May Adult N again had a telephone consultation with his GP, this time for personal health issues unrelated to alcohol-dependence. He was treated appropriately with antibiotics. On 13th May Adult N had his final consultation with his GP. This was a follow-up to the health issue treated on 4th May and also for lower back pain. He was conveyed to CHFT where a musculoskeletal problem was diagnosed. He was discharged with medication. The GP was informed by letter. No concerns were noted on this occasion regarding self-neglect or alcohol abuse.

5.76. On 18th May a Pharmacy had been unable to contact Adult N regarding repeat of medications for back pain that he had requested. He needed a GP appointment before repeat medications could be issued. Adult N was later contacted by the GP practice to let him know he needed an appointment. He did not respond. **Commentary:** there does not appear to have been any follow-up. It may have been that a letter was sent to his mother's address and Adult N may no longer have been living there. Certainly it was not straightforward for his GP (or other services) to contact him to arrange appointments. Alternatively, his alcohol-dependence and self-neglect may have made it difficult for him to initiate appointments.

5.77. On 24th May WYP received a telephone call from a third party reporting that Adult N was at his address, extremely drunk and was going to drive his car. WYP attended. Adult N

was found conscious and breathing but very drunk and had started to shake. 5 empty bottles of whiskey were next to him. He complained of pain in his groin. An Ambulance was requested and he was left in the care of paramedics.

5.78. CHFT recorded a seizure-related attendance having been found by his landlord intoxicated. He had a large amount money in his possession (over £3000). He was admitted to a medical assessment unit. He was experiencing withdrawal symptoms and also pins and needles after a fall from a trolley. He reported currently feeling very depressed, with no suicidal intentions or ideation but equally no interest in living. He denied any active attempts to self-harm other than drinking to excess. He said that he had just been made homeless by his landlord, and had no family, friends or support worker on whom he could rely. He also stated that he had been admitted to hospitals in Harrogate and York in the last few months. Numerous bank and credit cards were deposited in the general office. He appeared keen to see the MHLT and Alcohol team. At points he was confabulating and confused during this admission.

5.79. On 27th May MHLT received a telephone call from a Ward at Huddersfield Royal Infirmary identifying that Adult N had been admitted 3 days previously due to having seizures in relation to alcohol withdrawal. It was noted that he was drinking between 1-3 litres of vodka a day and that he had other admissions to CHFT and in York recently. Due for discharge the following day, the ward staff were concerned that he was drinking as he was depressed[43]. MHLT attempted to contact Adult N on the number that they were provided with by Ward staff, but the call went to voicemail. They made several attempts and discussed with Ward staff that Alcohol Services were the most appropriate service. Ward staff were informed that, if unable to contact Adult N, they would discharge him from their caseload.

5.80. On the 28th May, during this hospital admission, he stated that he would be living in his car as he was currently homeless. On this admission Adult N listed all his concerns. A complex discharge planning process began, and the Discharge Co-Ordinator was contacted regarding housing. Anti-depressant medication was continued. A phone was arranged to be delivered so that the Substance Misuse Team could talk to him privately and assess him. The Alcohol Liaison Team provided a phone number for him. Without informing staff he went to general office and took out the money and cards and gave them to the ward nurse.

5.81. He was reviewed by MHLT over the phone and not found to be significantly depressed, with alcohol services suggested as best placed to meet his needs. No further input was arranged by MHLT as secondary mental health input was not assessed as required. He was signposted to his GP and to CHART. Adult N had telephoned his mother earlier in the day and she contacted the ward but did not want him to know. Adult N was not happy for information to be shared with her. Kirklees Housing arranged for a temporary flat and he attend their office to sign for his temporary accommodation; he later returned to hospital for his medication, having obtained the keys. He was discharged on 29th May. A discharge letter was sent to his GP, noting alcohol-related issues and his new address.

[43] As stated in the combined chronology for the case. As noted in the previous section, an entry from CHFT recorded that Adult N had stated that he was feeling very depressed and had been prescribed anti-depressants.

5.82. **Commentary:** There was exchange of information and liaison between Ward staff and mental health and substance misuse services. However, no adult safeguarding concern was referred, nor was Adult N referred for a care and support assessment that would, for example, have explored what support he might need to sustain himself in the temporary accommodation that was allocated. He is reported to have stated that he was independent but knowledge of the history of the case might have indicated the need for an assessment. In a telephone conversation between Kirklees Single Point of Access (SPA) and Adult N, his presenting problem was seen as alcohol-related. Adult N seemed willing to engage with CHART but also enquired about mental health support. Nonetheless, no mental health concerns were noted and, therefore, the extent of any depression, and what lay behind it, remained masked. He was discharged by SPA and MHLT. The Alcohol Liaison Team did not see him as part of in-reach provision in hospital, due to the pandemic. CHART intended to pick the referral up in the community once discharged.

5.83. CHART attempted to contact Adult N on 1st and 3rd June, without success. An appointment was sent by text for 8th June, a reminder being sent on 5th and 7th. He failed to make contact and did not attend the appointment. Contact was made with his mother who stated that he no longer wanted to live. She also shared information about a large loan that he had taken out in January 2020. A letter was sent for his mother to give him. Contact would also be attempted through his GP. Attempts to contact Adult N on 9th and 11th June also failed. Housing Solutions contacted the accommodation provider who confirmed that Adult N was using his flat. It was agreed to complete a welfare check. **Commentary:** based on the information available, making contact with his mother was good practice. Persistent efforts were made to contact Adult N but by telephone and text.

5.84. On 12th June CHART sent a "7-day" letter to Adult N at his mother's address. This is a standard letter advising a disengaged client that if they do not make contact in the next 7 days they will be closed to the service. It also makes them aware that they can re-refer at any time should they still require support. **Commentary:** it is questionable whether, given the history, this was an appropriate response.

5.85. Also on 12th June a Housing Officer undertook a welfare check and found Adult N in his room, unresponsive and cold, heavily saturated in urine. Initially the Officer and the Ambulance crew thought that Adult N had died. YAS transported him to Huddersfield Royal Infirmary (CHFT) where self-neglect and intoxication were identified. WYP attended his room but after YAS had left with Adult N. CHFT staff also noted some suicidal thoughts but Adult N was not acting on them. He reported living alone in a flat provided by the council. Records contain reference to Adult N having capacity. He was discharged once medically fit, with a discharge letter being sent to the GP practice. Housing Solutions records suggest that he self-discharged. **Commentary:** the welfare check was good practice. However, no service appears to have referred an adult safeguarding concern at this point. No risk management multi-agency meeting appears to have been considered. It is unclear whether Adult N's mental capacity was formally assessed.

5.86. ASC have reported that GTC received a notification of concerns about Adult N's self-neglect from a Housing Officer. A referral form was sent for completion. **Commentary:** it is unclear whether or not an urgent response was being requested.

5.87. Housing Solutions submitted a formal self-neglect referral using the self-neglect toolkit and pathway on 16th June. ASC sent the referral to Huddersfield Hub. Housing Solutions undertook a further welfare check. Adult N was found to be asleep but no concerns were recorded about his immediate health. Staff chose not to wake him. Concerns were raised over the condition of his flat as the bed was heavily soiled with urine and vomit was on the floor of the property. A Housing Officer requested information about Adult N from his GP. When the GP surgery was unable to contact Adult N for his consent to share the information requested, a best interest decision was taken and information was shared the same day. **Commentary:** The self-neglect referral from Housing Solutions was good practice, as was the welfare check. The GP seeking Adult N's consent to share information was good practice but then, when consent could not be obtained, sharing information in his best interests. The Data Protection Act 2018 does permit the sharing of information to safeguard an adult at risk. There is the first and only reference to self-neglect procedures at this point, where Housing Solutions had told the GP surgery that KSAB's self-neglect procedures had been invoked.

5.88. Subsequently, Adult N's sudden death was reported. He had passed away in his room.

6. Analysis

6.1. From the foregoing commentary on the chronology, themes were extracted for further analysis. Discussion and reflection on these themes have taken place at a learning event, involving practitioners and operational managers who worked with Adult N or had involvement at the time with his case, and at the panel overseeing the conduct of the review.

6.2. It is important to recall here that the SAR referral raised the possibility of neglect and/or acts of omission by various services involved in the case.

Direct Practice with Adult N

6.3. Making Safeguarding Personal is a core component of adult safeguarding practice with individuals. There is evidence that staff at CHFT discussed options for support with Adult N, which he declined. There is evidence that he was reluctant to visit and/or stay with his mother because of the COVID-19 pandemic and her underlying health problems. His sister has confirmed that his mother has complex disabilities and resides in a one-bedroom bungalow. Adult N had to sleep in a chair or on the floor when he stayed there. At least one of his consultations with his GP discussed his misuse of alcohol.

6.4. Nonetheless, little is known about his wishes, feelings and desired outcomes. This may partly be explained by the limited contact that some services had with Adult N and the fact that no care and support assessment (Section 9 Care Act 2014) was undertaken, nor an adult safeguarding enquiry (Section 42 Care Act 2014) begun. Nonetheless, at least one participant at the learning event knew that Adult N had expressed anxiety that he could die and noted that he had attended for tests periodically. It was suggested that this could have been picked up and followed through with Adult N, especially when repetitive patterns emerged, of presentations at Emergency Departments and erratic engagement with service providers.

6.5. Another core component of best practice with individuals centres on thorough assessment. No referral for a care and support assessment appears to have been sent to Adult Social Care in Kirklees. This despite the fact that Adult N appeared to have care and support needs, which arise from or are related to physical or mental impairment or illness, which can include conditions as a result of substance misuse. In terms of possible eligible needs, maintaining a habitable home environment and maintaining personal hygiene appear to have been difficult for Adult N. This has been acknowledged at the learning event as a missed opportunity to look at the pattern of the case over time.

6.6. In the final two months of his life, when in Kirklees, no mental capacity assessment was undertaken. SWYPFT had limited interaction with Adult N, namely one telephone contact. Neither this, nor discussion with practitioners in other agencies, raised concern about his mental capacity with respect to care and treatment decisions. Principle one of the Mental Capacity Act 2005 was applied, namely that a person is assumed to have capacity unless it is established that they do not. It appears also that, from telephone contact, the GP did not have concerns regarding Adult N's mental capacity. Mindful again of the first principle, the GP believed that Adult N was responding appropriately. CHFT has reported that some consideration of mental capacity was found in hospital records but, again, the presumption

of capacity was influential. NICE guidance[44] recommends that individuals with a possible need for alcohol treatment services should have an assessment of cognitive functioning, not least because of the possibility of alcohol-related brain damage that can impact on their understanding of their circumstances and the treatment being offered.

6.7. Adult N at times clearly seems to have appreciated that he needed support, for example from CHART. He was signposted to that service by his GP and by SWYPFT. His GP was apparently confident that Adult N would contact CHART but this may have been an overoptimistic assessment given his alcohol-dependence and apparent inability to sustain temporary accommodation. However, he did not always act on stated intentions, and it does not appear that Adult N initiated contact with CHART. In the background also is evidence of several unsuccessful attempts at detox and rehabilitation. A question to consider, therefore, is whether reliance on what Adult N said meant an over-optimistic assessment when considered against his actual (and repetitive behaviour). Was his spoken word, in effect, a cloak of competence, masking an absence of executive functioning? Had prolonged alcohol-dependence created an impairment in the functioning of his mind or brain? Was his alcohol-dependence evidence of an impulse control disorder? There is no evidence that these questions were considered. This may partly be explained by the lack of knowledge about the involvement of services in Harrogate and in Leeds. Had this been appreciated, a more extensive picture of his alcohol-dependence would have emerged.

6.8. At the learning event it was suggested that practitioners find assessment of executive capacity challenging and require an enhanced skill level to do this. It was also suggested that practitioners "stumble" on capacity assessments, especially with respect to alcohol or drug-dependence and cases where mental capacity may fluctuate. It was also recognised that, at times, Adult N may have misled practitioners by referring to "binge" or "social" drinking rather than a pattern of dependence. Practitioners may have been reassured by his explanations and by his articulate accounts when sober of what he intended to do. It was also recognised, as the chronology of the case highlights, that he did on occasion initiate and attend appointments, even if this was not sustained. It was acknowledged that there could have been greater professional curiosity, with more proactive exploration of his history.

6.9. NICE guidance advises that consideration of mental capacity should include assessment of executive capacity. It recommends that assessment should include real world observation of a person's functioning and decision-making ability[45], with a subsequent discussion to assess whether someone can use and weigh information, and understand concern about risks to their wellbeing. It focuses on the person's ability to put a decision into effect (executive capacity) in addition to their ability to make a decision (decisional capacity). Local guidance, supported by a multi-agency training programme, would help practitioners to develop confidence and skills in assessment of executive functioning.

6.10. His sister suggested that Adult N's addiction to alcohol was an illness. She suggested that he had become depressed, and that his use of alcohol had depressed him further. She strongly asserted that alcohol-dependence and self-neglect is "not a path people choose" and that "there is always a story, a background." She found it frustrating that he was just signposted to services, with the repeating pattern not being picked up and addressed.

[44] NICE (2011) Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful drinking (High-Risk drinking) and Alcohol-dependence. London: National Institute for Health and Care Excellence.
[45] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Care Excellence.

6.11. A third area for assessment is mental health. SWYPFT staff had one telephone contact with Adult N on 27th May, which concluded with no cause for concern. CHFT records include an observation that there was no underlying mental disorder. Nonetheless, Adult N had reported feeling depressed and had been prescribed medication for anxiety and depression. The view from practitioners in the Mental Health Liaison Team appears to have been that Adult N was not significantly depressed and that he would be best supported by alcohol services. He was, therefore, signposted and also referred to CHART. At the learning event it was questioned whether signposting was sufficient. It was recognised that drug and alcohol providers offer a "consent service" but it was also observed that there appear to have been few referrals to substance misuse services. The chronology indicates that attempts were made to reach out to Adult N but when he disengaged, or moved between areas, this did not trigger multi-agency discussions that resulted in risk mitigation action plans.

6.12. CHART received a referral from SWYPFT on 27th May. In-reach was attempted the same day but was unsuccessful. A mobile phone was provided so that Adult N could make contact. CHART was not advised of his hospital discharge but several attempts were made to contact Adult N by telephone and text. None of these were successful, as a result of which CHART sent an opt-in letter to which Adult N did not respond, possibly because it was sent to his mother's address rather than to his temporary accommodation. In order to begin an assessment, outreach does not appear to have been considered. Adult N was not out of sight. Staff from Housing Solutions did undertake welfare checks, evidence of outreach and concerned curiosity that was good practice. Neither mental health nor substance misuse practitioners did the same. He had been discharged by MHLT, was not under SWYPFT, and CHART were requiring Adult N to opt-in.

6.13. Reviewing how services responded to Adult N's situation in the final months of his life, work was essentially crisis intervention, for example in secondary health care (CHFT) and in providing him with temporary accommodation (Housing Solutions). These were attempts to meet his most pressing needs. However, intervention was episodic. Each incident appears to have been responded to as a separate "referral" rather than any consideration being given to the pattern, the accumulation of episodes and whether a coordinated multi-agency plan was necessary to attempt to reduce the risks of harm.

6.14. The episodic approach is especially evident in terms of hospital discharge. Hospital discharge is an important transition, an opportunity to construct wrap-around care. However, more often than not, the opportunity they represented for attempts at a coordinated and collaborative approach to meeting his needs was missed. Within one locality and also when he moved between localities, services started again. Repeating patterns should be addressed through assessment and intervention plans that recognise and respond to cumulative risk. Risk assessments, plans and reviews are also advised to avoid practitioners becoming desensitised to the possibility of significant harm.

6.15. Another core component of the evidence-base for direct work in self-neglect cases is "thinking family." GP records contain an entry on 1st May that Adult N was living with his mother and that she had raised no concerns although she was aware of his alcohol-related hospital admissions. Adult N had also expressed concerns about the pandemic and not wanting to expose his mother to COVID-19 if he were to stay with her. No-one appears to have considered asking Adult N's mother for information that she may have held that might have enabled services to understand more about his presentation, especially his alcohol-

dependence and self-neglect. Although Adult N did not want information to be shared with his mother, when she made contact with practitioners and services, she could have been asked for her perspective and opinion, which would not have breached Adult N's wishes.

6.16. Similarly, his sister described five years of trying to find him, of times when he would not say where he was, of occasions when he would pass out for days. She believed that family members had been left to cope and that they had felt helpless.

Team around the Person

6.17. There is evidence of communication between services. CHFT sent discharge letters to the GP practice that implicated alcohol in his presentations at hospital. Housing Solutions staff liaised with other agencies when resolving whether to offer emergency and temporary accommodation. CHFT staff referred Adult N to the Mental Health Liaison Team.

6.18. Not all agencies may have had a complete picture, mainly because no multi-agency (risk management) meeting was convened. SWYPFT, for example, has commented that they held no information about the history of Adult N's self-neglect that would have indicated a pattern of risk[46]. Housing Solutions has acknowledged that it did not take the lead in convening a multi-agency meeting to discuss Adult N's self-neglect, housing need and risks. Housing Solutions observed that here was a "grey area" regarding which service should take the lead, acknowledging that a multi-agency meeting should have been convened early in the case and that there was therefore a need to strengthen and clarify expectations about working together in complex, challenging and/or high risk cases.

6.19. ASC has also observed that a multi-agency or multi-disciplinary meeting could have been arranged by early April 2020 using the self-neglect pathway. WYP has observed that the absence of an Adult Multi-Agency Safeguarding Hub (MASH) meant a greater reliance on individual Police Officers to identify and progress safeguarding concerns.

6.20. It was suggested at the learning event that multi-agency meetings are common practice in Kirklees. However, what is striking in this case is the absence of multi-agency meetings across the three areas where Adult N presented repeatedly with problems associated with homelessness, alcohol-dependence and self-neglect. The result was an episodic and rather disjointed approach to meeting his needs.

6.21. Adult N had spent time in both Leeds and Harrogate before his arrival or return to the Kirklees area in March 2020. It does not appear that any agency sought information from services in those two areas in order to build up a picture. At least one service, Horizons in North Yorkshire, had been told by Adult N that he had moved to Kirklees. This raises a question as to when a cross-border alert process might be indicated.

6.22. During the final months of his life one specific geographical boundary issue also arose, namely the involvement of Calderdale Emergency Duty Service and Kirklees Emergency Duty Service. This arose specifically when Adult N was found at Halifax station and WYP contacted both services in order to attempt to resolve his homelessness, raising a question about which Emergency Duty Service would accept responsibility for him.

[46] MHLT, based in CHFT, is part of SWYPFT and has access to both CHFT and SWYPFT records.

6.23. A core component of an effective team around the person is safeguarding literacy. WYP has acknowledged a missed opportunity to refer Adult N to ASC on or around 11th April 2020. YAS does not appear to have referred any adult safeguarding concerns other than in September 2019 when he was found in Harrogate. Housing Solutions did refer Adult N to GTC around 16th June 2020, concerned about his self-neglect but Adult N died before a formal decision could be taken about whether to progress this referral to an adult safeguarding enquiry (Section 42 Care Act 2014). LTHT has acknowledged that no adult safeguarding concerns were referred, despite Adult N's repeated presentations at Emergency Departments in Leeds. The Trust has initiated an action plan to address this practice shortfall.

6.24. Throughout his involvement with different services in Kirklees, Adult N appeared to have care and support needs, to be experiencing abuse and neglect (in his case self-neglect) and to be unable to protect himself because of his care and support needs. The same could be said when he was presenting to Emergency Departments in Leeds and on other occasions when he came to the attention of YAS in North Yorkshire. There were missed opportunities throughout this period to refer adult safeguarding concerns, which might have also led to multi-agency partnership working in order to mitigate risks.

6.25. One explanation given at the learning event for the omissions concerning referral of adult safeguarding concerns was that services assumed another practitioner or agency would refer. Asking safeguarding questions should be standard practice, for example in Emergency Departments, and where indicated referrals should be made regardless of whether another service might be doing the same.

6.26. Another core component of effective multi-agency working is legal literacy. ASC has commented that there is no evidence that different legal options were considered. WYP has observed that Section 136 Mental Health Act 1983 can only be used when the person is in a public space. When resident in hotel rooms as temporary accommodation, that power may not have been available, depending on the precise arrangement that had been agreed. However, the power would have been available when Adult N was found in his car and/or at a train station by WYP if an underlying mental health concern had been identified. On at least one occasion, events on 17th April beginning at Halifax station, it appears that Adult N was not assessed as having a mental health episode.

6.27. It should also be noted that being drunk in charge of a vehicle may be classed as an offence. Adult N could also have been referred to DVLA by his GP.

6.28. In Kirklees, Housing Solutions did assess Adult N using the provisions of the Homelessness Reduction Act 2017. He was found to be in priority need and was provided with interim accommodation. Nor did Housing Solutions terminate his priority need status when he was evicted from hotels because of his self-neglect. This was good practice, using discretion and flexibility in an attempt to meet his needs. NHS Trusts have a duty to refer individuals who are homeless, or threatened with homelessness, under the Homelessness Reduction Act 2017. As the chronology identifies, there is evidence of Emergency Department staff raising accommodation questions with Adult N and being reassured by what he said regarding the availability of accommodation, or sharing information with Housing Officers. There were other occasions when it is much less clear whether this was done.

6.29. Information-sharing is also key to effective multi-agency working. Information was shared by the GP with Housing Solutions in his best interests. This disclosed medication that had been prescribed related to Adult N's alcohol-dependence. The Data Protection Act 2018 permits the sharing of information in order to safeguard an adult at risk. CHFT shared information with the GP practice relating to Adult N's treatment in hospital. However, CHART was not advised that Adult N had been discharged from hospital towards the end of May 2020. Nor did CHART contact Adult Social Care, for example when their involvement was closed because Adult N did not engage, which was recognised at the learning event as a gap.

6.30. One specific issue relating to records has emerged in this case. Transfer of GP records is via a central repository. There is often a delay in transfer of records from one GP practice to another. Adult N's records were not received by the GP practice in Kirklees before he died. Consequently his last GP was unsighted on historical information regarding his alcohol-dependence and mental health. At the learning event it was suggested that transfer of GP records is a national issue that should be escalated to NHS England and NHS Improvement.

6.31. Additionally, it appears that the IT recording system used in the Kirklees GP practice was different from that used by other provider services, with the result that the GP could not easily obtain information about how other agencies were involved.

Organisations around the Team

6.32. There is very limited reference to the self-neglect pathway in the information provided by the agencies involved for this SAR. The pathway should be triggered where a person's life is under threat, where an impairment of, or deterioration in a person's physical or mental health is evident, and where there is serious, chronic or long-lasting impact on health and on physical, emotional and psychological wellbeing.

6.33. At the learning event there was general acknowledgement that practitioners were aware of the self-neglect pathway. However, revised procedures had been launched in March 2020 and it was suggested that an audit of their use would be helpful. It was also suggested that procedures to follow for individuals with multiple and complex needs may be insufficiently clear, especially if significant risks remain despite multi-agency meetings, planning and information-sharing. There was reference at the learning event to the need to raise the profile of the risk escalation conference, chaired by Adult Social Care. This should be used when all other avenues have been exhausted. Multi-agency and newly launched, it was suggested that an audit of its use would be informative.

6.34. Equally, there was reference at the learning event to an alcohol management pathway but also to how quickly individuals can become lost to the system, for example when discharged or when they self-discharge from hospital. Adult N's alcohol-dependence was well-known to services in North Yorkshire and Leeds as well as in Kirklees. Further scrutiny of such a pathway would appear indicated given the repeating pattern of Adult N's presentations and of the responses by services that encountered his alcohol-dependence and self-neglect.

6.35. Adult N was well-known to services in North Yorkshire, Leeds and Kirklees. It appears, however, that there was no cross-border information-exchange or inquiry. Safeguarding Adults Boards in the Yorkshire and Humber region could take the lead in

reminding partner agencies of the importance of cooperating across local authority boundaries. Adult N did disclose to some services that he had moved from one area to another and yet this does not appear to have prompted professional curiosity and inquiry.

6.36. Adult N was not in an acute mental health (psychotic) crisis but appears to have experienced mental distress. A question to consider, for commissioners and providers, is what support is available for people experiencing ongoing forms of mental distress. A further question for commissioners and providers arises in relation alcohol-dependence and dual diagnosis. The expectation appears to have been that individuals would self-refer once signposted to services. It is questionable whether this expectation is reasonable in all cases. SWYPFT has provided detail of a dual diagnosis pathway via assessment by a Single Point of Access Team. Whilst Adult N was formally referred to CHART at the end of May 2020, there is a question about whether the pathway worked sufficiently well in this case.

6.37. In the initial information provided for the review it was stated that GPs in Kirklees are not permitted to prescribe alcohol detox. At the learning event, it was clarified that, if GPs have the necessary capacity and competence, they can prescribe alcohol detox medication. Otherwise, the referral would be to CHART. Public Health in Kirklees has stated an intention to write to all GPs on this topic. Commissioning a community detox house in Kirklees is also being considered.

6.38. Increasing use is also being made of colocation. Housing Solutions have a dedicated practitioner focusing on hospital discharge, which is how Adult N became known. A Social Worker and a Drug and Alcohol (CHART) Worker are attached to the Rough Sleeper Team.

7. Conclusion and Recommendations

7.1. The commentary in section 5 of this report and the analysis in section 6 has sought to address explicitly the terms of reference for the review.

7.2. The final months of Adult N's life coincided with the COVID-19 pandemic and the first national lockdown. Some services have reported that this did not unduly impact on their work. For example, Housing Solutions undertook welfare checks in a timely manner and fulfilled their statutory duties towards people experiencing homelessness. Other providers have observed that making contact with Adult N was more problematic, even when he had been provided with a mobile phone, due to remote working, and that consultations, for example with his GP, were telephonic. It has been suggested that a physical consultation might have revealed that he was coping less well than he was articulating. Fusion Housing has observed that there was reduced throughput and therefore fewer vacancies at this time, and the pandemic also had an impact on response times.

7.3. This mixed impression on the impact of the pandemic is not surprising. Adult N died just towards the end of the third month of the lockdown, at which time adjustments to "new ways of working" were unfolding in the light of central and local government guidance, with particular operational pressures being experienced. Much of how services responded to Adult N predated the pandemic and the themes, which inform the recommendations below, have emerged from consideration across the entire period under review, that is before and after the onset of the pandemic.

7.4. His sister has expressed the hope that this review will help to raise awareness of the need for a coordinated and collaborative multi-agency approach to alcohol-dependence and self-neglect.

7.5. This case is not unique. A previous SAR in Kirklees[47] found good practice in terms of perseverance to engage with an individual whose presentation included self-neglect and substance misuse, and communication between services. However, shortfalls were found concerning mental capacity assessment, use of the self-neglect pathway and multi-agency meetings, and support and supervision for staff. The self-neglect pathway was reviewed and relaunched as a result, including strengthening procedures for convening multi-agency meetings. There has been a renewed focus on effective supervision and support, and on information-sharing. **Recommendation One:** KSAB should consider auditing the outcomes of the revised and relaunched self-neglect pathway.

7.6. The first ever national analysis of SARs in England[48] has identified common shortfalls in practice, which correspond with what has been found in Adult N's case. These include superficial or overlooked assessments, lack of professional curiosity and a failure to think family, and alcohol abuse not being seen as self-neglect. The reported shortfalls also include services not working together, an absence of referrals of safeguarding concerns and a lack of protocols to guide staff. More positively, some reviews found good practice – wrap-around support for individuals; liaison between providers of mental health and physical health care, and drug and alcohol services, and robust risk, care and support, mental health and mental

[47] Adult L.

[48] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.

capacity assessments. **Recommendation Two:** KSAB should consider convening a summit of commissioners and provider to review the response to individuals who are alcohol-dependent, and specifically whether there are gaps in practice and in services, drawing on the evidence-base for working with individuals who self-neglect and/or are alcohol-dependent. **Recommendation Three:** KSAB should consider how it can support practitioners to include executive functioning in mental capacity assessments. **Recommendation Four:** KSAB should consider auditing the use of multi-agency meetings, including the risk escalation conference.

7.7. Adult N moved across local authority boundaries, with the consequences that assessments for service provision started again, representing some loss of continuity of care, and loss of relevant information. **Recommendation Five:** KSAB should consider engaging in a regional conversation with other SABs in the Yorkshire and Humber region about how to facilitate exchanges of information. KSAB should also share this report with Leeds Safeguarding Adults Board and North Yorkshire Safeguarding Adults Board so that these Boards and their partner agencies can pay due regard to the findings and lessons to be learned. **Recommendation Six:** KSAB should consider sharing this SAR with NHS England and NHS Improvement, with specific reference to the transfer of GP records.