Adult N
Safeguarding Adults Review

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1. **The Case Review**

1.1 Introduction

On 13 August 2020 a decision was taken by Newcastle Safeguarding Adults Board (NSAB) to undertake a Safeguarding Adult Review (SAR) following the death of Adult N. Adult N was a White British 58-year-old woman who died in February 2020. The final cause of death was Acute Cardiorespiratory Arrest and Ischemic Heart Disease. However, Adult N was known to have been in a volatile and abusive relationship with her partner including physical, emotional and financial abuse, and was subject to similar abuse from others, since approximately 2012 up until her death. She was subject to, physical abuse in the days prior to her death. As a result, she was the subject of 34 safeguarding concerns between 2015 and her death.

Adult N began to use alcohol and drugs at an early age, initially consuming alcohol from the age of 14. The exact age that she started to use drugs is unknown, but heroin and other opiates became her main drugs of choice over the next 40 years. Concerns existed around both her physical and mental health, and Adult N had an acquired brain injury after being knocked over by a bus in 2012.

1.2 Purpose of the Safeguarding Adults Review

The purpose of a SAR is not to re-investigate or to apportion blame, undertake human resources duties or establish how someone died. Its purpose is:

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults.
- To review the effectiveness of procedures both multi-agency and those of individual agencies.
- To inform and improve local inter-agency practice.
- To improve practice by acting on learning (developing best practice).
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

There is a strong focus on understanding issues that informed agency/professional's actions and what, if anything, prevented them from being able to properly help and protect Adult N from harm.

1.3 Independent Review

Mike Ward was commissioned to independently chair the panel of agency contributors and write an overview report. He has been the author of several safeguarding adult reviews as well as drug and alcohol death reviews and a member of a mental health homicide inquiry team. He worked in adult social care for many years but in the last decade has worked mainly on developing responses to change resistant dependent drinkers and drug users.

1.4 Agencies Involved

The following statutory agencies were involved with Adult N and/or her family:

- Newcastle City Council (Adult Social Care)
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

- Northumbria Police
- North East Ambulance Service
- Primary care / Newcastle Gateshead Clinical Commissioning Group
- Department for Work and Pensions (DWP)
- Tyne and Wear Fire and Rescue Service
- National Probation Service, Northumbria (in relation to other people in her life, Adult N was not managed by the Probation Service during the review period)

The other agencies who have contributed to the Safeguarding Adults Review are:

- Boots Pharmacy
- Tyne Housing
- Your Homes Newcastle
- St Anthony of Padua
- Your Voice Counts (Advocacy organisation)
- Changing Lives Domestic Abuse Women's Intensive Support Worker (WISW)

1.5 Review process

The chair and NSAB agreed Terms of Reference for the review (see appendix 1). Each of the above agencies contributed an Independent Management Report (IMR), this included a general overview of their involvement, responses to the questions raised by the Terms of Reference, a chronology and identified learning for the agency. A unified chronology was developed by the SAB from the information in the IMRs.

Agencies also attended a Practitioners' Workshop chaired by the SAR author (February 2022). This sought to clarify and deepen the understanding of the material in the IMRs. Once this event was completed, the author drafted an initial version of the report which went back to the NSAB in March 2022. This was subject to agency comment and a further draft was produced for the NSAB in May 2022.

There were some delays against the usual timescales in progressing this SAR. This was as a result of the NSAB receiving several SAR referrals at the same time and the impact of Covid-19. The NSAB therefore, undertook a robust process to identify how to manage the workload for agencies within the resources available.

The author is very grateful to the various agencies, the IMR authors and other practitioners for their involvement and the honesty of their reflections.

1.6 Family Involvement

Because of the nature of Adult N's relationships with her partner and his family, it was not deemed appropriate to consult them for this review. She has one surviving son but again it was not felt appropriate to consult him in this process. This decision was the subject of consultation with the many agencies who worked with Adult N.

However, in the last years of her life, Adult N had a Care Act Advocate who supported her through important decisions that emerged from the safeguarding process. He was able to provide an independent perspective on Adult N and her life. His input to the process was particularly appreciated by the author.

1.7 Parallel processes

There were no parallel processes such as Police or Coronial inquiries that coincided with the SAR process.

The NSAB SAR Committee considered whether this case was appropriate to be referred for a Domestic Homicide Review (DHR), however as Adult N's cause of death was not attributed to domestic abuse this was not required.

1.8 Terms of Reference

The terms of reference for this review are included in Appendix 1. These informed the development of the Independent Management Reviews and the thinking about this SAR. However, they have not been used to structure this review because the review process opened up new learning about the themes to be prioritised in the report and how that material should be presented.

2. Adult N – a brief history

Adult N was a 58-year-old woman at the time of her death. She experienced significant trauma during her life. Her father had an alcohol use disorder and was abusive towards her mother. Adult N stated that she had been scared of her father.

She had a lifelong history of drug and alcohol use disorders herself. It is reported that she began drinking alcohol initially from the age of 14. She then began a pattern of heroin and opiate use which continued for approximately 40 years up until her death and also included the use of illicit benzodiazepines and more occasionally crack cocaine.

The picture of her alcohol use is more confused. Some of the IMRs suggest, for example, that *Adult N was misusing drugs and alcohol on a daily basis.* Another IMR reported that Adult N's engagement with services became erratic and suggested that *this was probably due to her alcohol misuse*. However, other agencies and, in particular the discussions at the practitioners' workshop suggested that in the period under review alcohol use was not a significant problem for her. For example, although the Pharmacy would see Adult N on a daily basis, she was never refused her script for being intoxicated.

For most of her adult life she was on an opiate substitution therapy programme and would attend the chemist daily for a prescription of methadone. Although she was generally compliant with this programme; her engagement with Substance Misuse Services themselves was more chaotic. Throughout the period of treatment, Adult N rarely attended scheduled appointments as planned; attending late and regularly missing planned reviews. Substance Misuse Service staff proactively confirmed with the Pharmacy when she did not attend appointments to ensure an uninterrupted prescription, and to address any risks presented by her chronic drug use.

However, it was reported that she also had periods where she would disengage from professionals and stopped picking up her methadone scripts; at which point she was thought to be increasing her use of illicit drugs.

Drug and alcohol use disorders also characterised her relationships. She had been married, but her husband passed away from a drug overdose. She had two children by that relationship. One son died from an epileptic seizure. Her second son was also known to have a drug use disorder. After the death of her husband, she formed a relationship with another man who also had a substance use disorder and who had children who had substance use disorders. This latter relationship continued from 2012 until her death.

In the review period, behaviour associated with her, and others', drug or alcohol use were a cause of nuisance and distress to residents within her supported accommodation. These others included her partner and family but also, it appears, other known drug users who were seeking her out.

Adult N had significant problems with both her physical and mental health; many of these were the result of her drug use. She had diagnoses of Hepatitis B and C, Vitamin D deficiency, deep vein thrombosis of the leg related to intravenous drug use into her groin, peripheral vascular disease and a history of seizures. She had

previously attempted suicide via drug overdose; although suicidality does not appear to have been a significant part of her presentation during the review period.

One report notes *that Adult N was diagnosed with a Borderline Personality Disorder but that she is unsure how it affects her.* However, this diagnosis is not confirmed elsewhere. Adult N also disclosed that she often forgot to eat and would do so when prompted by her support worker. This contributed to an overall lack of self-care. She also reported high levels of anxiety and a consistent low mood.

A further theme that underpinned all of her interactions was head injury and cognitive impairment. The IMRs repeatedly comment on her poor or deteriorating memory. She would be a non-attender at hospital appointments or appointments with professionals and other support offered. Adult N herself stated that she found it "scary" when she could not remember things.

She had an acquired brain injury after being knocked over by a bus in 2012. She also had hepatitis C which can make people tired, confused and, as some patients call it, "brain fogged". Alongside the brain injury, this may have impacted on her situation in the period in question. It is also possible that she would have received further head injuries as a result of domestic abuse and assaults.

Mental Health Trust clinicians were aware of Adult N's head injury and the potential impact on her memory and function. She was referred for an assessment for an inpatient assessment in relation to the head injury. However, she needed to have abstained from street drugs for three months before the assessment could go ahead, which proved difficult to achieve. It had been hoped that the assessment would determine the impact the brain injury was having on her decision making.

In the period under review, an initial memory assessment was undertaken by her keyworker at the Substance Misuse Services. Adult N did not attend for the initial planned medical appointments; however, this was followed up and reviewed in May 2019. MRI and CT scanning were requested, and a referral made to Neuropsychology and Neuropsychiatry. Adult N did not attend the appointments offered, despite encouragement and prompting from Substance Misuse Service staff and a support worker from her accommodation offering additional support. At the time of her death, she was awaiting a further rescheduled appointment. A safeguarding meeting was planned where supporting engagement with this was due to be explored.

Adult N had a long history of engagement with the criminal justice system. The Police identified 55 crime records going back to 1997 with Adult N recorded as the victim in just over half of the reports and the offender in the rest. She was in prison for four and a half years at some point in her adult life (but prior to the review period). For the period under review, there are 10 police records: in one she assaulted an employee at a building society because she was having problems withdrawing money, but in the other nine cases she was the victim or the subject of concern. There were 18 domestic violence records since 2012 all regarding her partner. The police raised 11 safeguarding concerns.

However, in the context of this Review, the most significant aspect of her life is her vulnerability due to abuse from her partner, his family and others. She had several

MARAC codes on her Police major problem list and was coded as a vulnerable adult. She was also a victim of financial abuse from her partner and other family members. This is a sample of the entries relating to abuse in the chronology:

- In November 2017, the Ambulance Service were called to Adult N who was described as *being covered head to toe in bruises, some may be caused by taking IV drugs but other looks traumatic in nature.* Adult N had attempted to cancel the ambulance, but this did not happen because there was concern for the welfare of Adult N. At that point, the patient was 'flagged' on NEAS systems as a Multi-Agency Risk Assessment Conference (MARAC) case.
- In December 2017, it was disclosed that Adult N's son had been recently released from prison and was financially abusing her.
- Until the end of October 2018, there was a Domestic Violence Protection Notice (DVPN) in place to protect her from abuse by her partner. Her partner breached these conditions refusing to leave Adult N's address, there were verbal arguments and a physical assault where Adult N said he punched her in the back.
- In 2018, Adult N was awarded a large back payment from the Department for Work and Pensions (DWP). This led to concerns about exploitation by her partner which ultimately resulted in an appointeeship.
- In May 2018, she reported that she had been targeted by a group who had been exploiting her and taking advantage of her financially. This resulted in a mugging and burglary. Adult N's mental health had worsened as a result. She reported rarely leaving the house and described self-neglect during assessment.
- In September 2018, Adult N submitted an online Housing Application: the reason specified for moving was harassment.
- In October 2018, the MARAC notes list Adult N as a high-risk victim of Domestic Abuse.
- In February 2019, her partner was arrested for an assault on Adult N.
- In July 2019, Adult N came to the property of her partner and stated that "she had money for him to stop him from beating her up. In the same month, she reported being beaten up by a stranger.
- A safeguarding referral submitted in November 2019 states that Adult N allowed a resident into her home after he produced a bottle of brandy. During the course of the evening, whilst in the property, the male resident assaulted Adult N by stroking both her breasts. Adult N reported this incident to staff.
- In February 2020, just before her death, Adult N reported that she has been assaulted by her partner's stepdaughter and son. They took her phone and she suffered a black eye.

In addition, Adult N reported being attacked by a stranger. On two occasions in August 2019 it is noted that young people knocked at the sheltered housing facility trying to find her. It is unclear whether these had threatening intent.

As a result of this abuse she was subject to 34 safeguarding referrals between 2015 and 2020. She was discussed at four Multi Agency Risk Assessment Conferences (MARAC) between September 2017 and January 2019. Specific actions were taken to protect her. For example, she had a domestic violence outreach worker and at the time she came into the large sum of money the Pharmacy was informed confidentially

of the situation and asked to keep an eye on her regarding the company she was keeping and let the Substance Misuse Service know of any concerns.

However, working with this abuse was not straightforward. Records from the Domestic Violence Service show that the worker attempted on numerous occasions to discuss domestic abuse with Adult N; however she often said she did not want to speak about it or would give limited information such as that her partner had been putting her down and calling her names without discussing anything further. A housing provider commented that she often presented with bruising after stating that she had been assaulted but when questioned further, she would have no memory or would state she hadn't been assaulted. Therefore, no further action could be taken.

Adult N also appeared to value the relationship with her partner. At a MARAC meeting it was noted that information from Adult N…*states that she wished to remain in a relationship with the offender*. The chronology highlights other references to Adult N's long-standing relationship with her partner. On one occasion, Adult N's partner spoke to a housing worker saying: "*all okay, having a cosy day with Adult N.*" On another occasion the same worker saw Adult N going out Christmas shopping with her partner and his son: *"…all looked happy, which was nice"*

It should also be noted that Adult N herself was violent or anti-social towards others. In February 2019, she was carrying three bags of Cannabis around her sheltered housing and offering them to other residents. In July 2019, Adult N had a verbal altercation with another resident over concerns that she was bringing people back to her flat to take drugs. In late 2019, a safeguarding concern was submitted for one of her neighbours due to the distress caused by Adult N. The referral listed Adult N as the abuser/perpetrator on this occasion. She was also verbally or physically abusive to staff in a building society and a chemist as well as to another client at the Substance Misuse Service.

The first safeguarding concern was made in 2015 and was due to the increase in her drug use and concerns for her safety from her partner. In this instance, it was felt all appropriate actions had been taken so no further action was taken. However, from 2017 there were 33 safeguarding concerns which were completed through all five stages of the process: referral, information gathering, investigation, plan and review and completion.

Adult N was open to safeguarding adults' procedures when she died and had been the subject of an assault on 31/01/2020 – a safeguarding adults meeting was planned for 11 days after her death. A strategy discussion (involving Adult N, her Advocate, Adult Social Care and Police) had taken place on the day of the assault and a safeguarding adults plan was in place.

A particular point of contention with Adult N was the management of money. She had been a target for financial abuse and work was carried out with her to ensure she did not put her tenancy at risk, that bills were paid and that she managed her money safely. Adult Social Care tried to set up support with care providers to assist with bill payments. They also considered social activities to prevent Adult N feeling lonely and continuing to use drugs or alcohol. However, Adult N was reluctant to receive any support where there might be a financial contribution required.

In 2018 Adult N was awarded a large back dated payment (£12-13,000) for severe disability benefit, half of this was spent within a short period, causing professionals concerns about her safety from exploitation by others and a potential increase in her drug or alcohol use. To assist with budgeting and financial management, to prevent risk and ensure Adult N had enough money for bill payment and rent, a Mental Capacity Assessment and Best Interest Decision was completed to look at the Local Authority taking on the role of Appointee to support with finances and give her a weekly amount to manage. Adult N was supported by an Independent Mental Capacity Advocate (IMCA) around this decision and by a support worker from Changing Lives due to potential domestic violence and financial abuse.

However, as time passed Adult N often became agitated wanting to manage this money herself and not wanting the Local Authority to manage this on her behalf. Adult N became fixated at times on her finances and was often verbally abusive to Social Workers and others supporting her. She would apologise for this behaviour a day or two later but would then forget what information had been shared with her and the rationale for not returning all her money to her and managing it on her behalf.

(It is interesting to note that new guidance has been issued to all DWP officers detailing steps to ensure that vulnerability is checked before a high value payment is made. An escalation route for further help and support is included.)

This payment also underlined the problems of abuse and exploitation. Her partner believed that he was entitled to half of this money and it is clear that Adult N did give him several sums and she disclosed that he threatened to get people to 'mess her up' if he did not receive £2000. As a result, her partner was further arrested for blackmail, which he denied, and this was whilst he was already in custody for an assault against her, which he also denied.

During early 2020 Adult N disclosed to her advocate that she was providing money to her partner's son every week. Services worked with Adult N to support her with this, due to how anxious she was about repercussions from the family members if they thought she had told someone.

The other major theme in the last years of Adult N's life was her accommodation. She moved to a sheltered housing unit in 2018, in the hope that this would help her live more independently. Alleged perpetrators known to her had attended her previous flat and caused trouble. It was felt that sheltered accommodation would offer more protection, given that others couldn't just turn up at the front door. She was living in this facility when she died. However, in this unit there were still problems associated with visitors to her property and consequent noise and disruption.

However, it should be noted that there were no issues in terms of the cleanliness of the property, it was sometimes described as messy but not cluttered. Care staff reported how she enjoyed buying things for her flat and liked to show the staff her recent purchases. Staff reported that she was well dressed and liked to buy herself "nice things". The one caveat to this picture is that after her death hypodermic needles were found in the property: the origin of these is unclear.

Adult N regularly allowed officers of her housing provider into her home. A quarterly inspection of the property took place, to check internal alarms, regardless of whether staff visited between the checks. There were never issues with Adult N in terms of allowing access.

3. Key themes

Adult N was a woman with multiple complex needs. She died at a relatively young age and as the result, in part at least, because of the effects of a drug using lifestyle. She was also the victim of domestic abuse from more than one person and may have had cognitive impairment due to head injury.

She is an example of a person that services may find difficult to engage with and who could easily have been excluded by many services. However, the response to her from local agencies was very good. Most services appear to have gone out of their way to try and support her. She had an advocate who worked hard to support her. She had proactive support from Substance Misuse Services and outreach support from both an Adult Social Care Substance Misuse Worker (this post is no longer operational) and Domestic Abuse Services. As has been said there were over 30 safeguarding referrals which were fully progressed by the local authority and her housing provider made efforts to maintain her tenancy despite the challenges posed. Consideration had also been given to an assessment of her cognitive functioning.

The IMRs highlighted many examples of joint and positive working:

- There were multiple consultations between her GP practice and her Social Worker or Support Worker.
- If she did not attend her daily appointment at the Pharmacy, that would be reported to the Substance Misuse Service. To support compliance with her medication. reminders were set up by the staff on her mobile which helped increase attendance Pharmacy staff always made conversation with Adult N to ensure her welfare as she had indicated in conversations that she was lonely and was “judged” by residents in her sheltered accommodation.
- Substance Misuse Services offered flexibility regarding Adult N’s problem in attending appointments on time, in order to keep her in treatment.
- Taxis were arranged for Adult N to attend appointments and bus fares were reimbursed.
- The Women’s Intensive Support Worker liaised with Substance Misuse Services regularly, supported Adult N to attend appointments and took her to collect her scripts from the chemist.
- Adult Social Care asked a local care provider to provide a morning medication prompt call for her.
- Her support worker told DWP that Adult N had a head injury which affected her memory. DWP accepted this mitigation and rebooked a missed health assessment appointment.

One of the IMRs comments that Adult N appeared to*: have a good level of support from her support and social workers. They were present at health assessments and occasionally rang on Adult N’s behalf to share information…Adult N appeared to have support in many different aspects of her life; mental health, daily living, addiction support, financial support, support for trauma (mugging/burglary) and food bank referrals when appropriate.*

Local services deserve praise for the response to Adult N. It is hoped that this level of support is on offer to everyone with complex drug and alcohol use disorders in the city.

The central question raised by her care is: “what else could this multi-agency system have done to protect someone who was *apparently* making repeated unwise decisions which resulted in ongoing risk of harm? It is likely that in her case the degree of choice involved was very limited due to issues such as coercion and control, substance use disorders, histories of trauma, mental capacity, and cognitive impairment. Nonetheless, the review needs to ask, “what else could have been done to mitigate this risky lifestyle?” There is no simple answer to this question, but the main section of this analysis (section 4) considers six possible approaches that had not been used in this case.

Subsequent sections focus on assessing alcohol use, fire risk and the role of the pharmacy.

4. Protecting someone who is repeatedly the victim of abuse

Adult N was the victim of violence, abuse and financial exploitation by her partner, members of his family and her own family. She also reported an assault/theft by an unknown person in a local park and on one occasion, she stated that she was sexually assaulted by another individual. This abuse not only caused her harm but also led to anti-social behaviour affecting her neighbours in her accommodation.

The main challenge was that Adult N appeared unwilling to support action against her abusers. It is easy for this to be viewed as a "lifestyle choice", but Adult N's case highlights the complex network of factors impacting on her decision-making – probably coercion and control, but also substance use disorders (both the effects of intoxication and the need to access drugs) and cognitive impairment which will impact on her decision-making.

Adult N's apparent history of trauma may also have had an impact on these choices. In the Ms. H and Ms. I Safeguarding Adult Review (Tower Hamlets), the partner of a woman who had died having experienced multiple exclusion homelessness, commented that: *she had been unable to maintain abstinence from substance misuse because past traumas and adverse life experiences "kept bubbling up."* The report goes on to say that: *This captures quite graphically how individuals can be governed by impulses to distance themselves from emotional distress. They can be caught in a life-threatening double-bind, driven to avoid suffering through ways that only deepened her suffering.*[1]

In addition, the practitioners' workshop highlighted that Adult N was part of a wider community (or sub-culture) that emphasised the need not to report ("grass people up") to the authorities and is physically dangerous to those who breach this code.

A considerable number of actions were taken to address the abuse, and the other problems, she experienced. The 34 safeguarding referrals were largely driven by her vulnerability. She was referred to MARAC, she had a domestic violence outreach and support worker, she was moved to a different property, and her partner received a Domestic Violence Protection Notice (which expired in 2018) to protect her from abuse.

There is no doubt that agencies made robust efforts to address her situation. This is not a case in which professionals failed to assess risk, use professional curiosity or communicate concerns: common failings in other Reviews. There is no evidence that practitioners were unaware of issues related to coercion and control or trauma. Nonetheless this is a Safeguarding Adult Review and it is important to consider the issues that are at the centre of the safeguarding concerns that led to this review. Could services have done more to better manage this situation?

This review is not suggesting an easy solution to this challenging situation. For example, one person at the practitioners' event commented on the cultural aspect that *working for the local authority for 30 years grassing comes up a lot, not sure how to tackle it, not putting relationships at risk, not admitting assaults, for vulnerable people this is a big question where I have no answer.* However, Adult N's needs highlight that people in her situation are not making lifestyle choices but are driven by a range of issues which need to be understood if people are to be helped.

This section explores six themes that could have been considered in addressing her needs:

- Tackling her drug use disorder – residential rehabilitation
- Using the Mental Capacity Act – assessing capacity to keep herself safe
- Addressing her cognition
- Using other legal frameworks
- Raising the level of housing support
- Multi-agency management and escalation

4.1 Tackling her drug use disorder – residential rehabilitation

The response that Adult N received from Substance Misuse Services was both flexible and assertive. It conformed to best practice in working with an opiate user in the community.

The question is whether residential rehabilitation should have been considered for her. It is likely that a detoxification followed by a period in a "dry" residential facility would have given her the best opportunity to escape the influence of the people who were abusing her, to allow her cognition to be assessed and to have considered what she wanted from her life in a supportive environment. None of the chronologies indicate that this was considered as an approach to addressing her situation.

Residential rehabilitation is an approach whose use has declined in the UK in the last 20-30 years and, as a result, the number of residential facilities has been declining. A recent Scottish government report[2] has said that: *"Residential rehabilitation treatment for drug and alcohol problems is a well-established intervention acknowledged in the (UK's) Drug Misuse and Dependence National Clinical Guidelines as an important option for some people requiring treatment. A recently published international review of residential treatment outcomes for substance use disorders, which included a methodologically strong study from Scotland, found evidence for the effectiveness of residential treatment in improving outcomes across a number of substance use and life domains.* It adds that: *European evidence[2] suggests that access to residential treatment is lower in the United Kingdom than in other European countries*.

In England, Dame Carol Black's *Review of drugs part two: prevention, treatment, and recovery* makes a similar point: *Local commissioning of inpatient detoxification and residential rehabilitation has decreased substantially in recent years, despite evidence of their effectiveness and importance for people with particularly complex needs. Local commissioning of such high-cost but low-volume services should be replaced with a regional or sub-regional approach.*

This is not an easy option. Adult N is very likely to have rejected any such offer. Moreover, it may not have succeeded even if she had agreed to attend a rehab. Detoxing Adult N was likely to be complex. It is also probable that there would have been problems finding an appropriate placement. However, in a very difficult and "stuck" situation it may have offered a route forward and Dame Carol Black's report highlights the importance of considering this approach with people with complex needs.

Access to residential rehabilitation may not have been the panacea that would have solved Adult N's problems. However, it is important that:

- such a route should have been considered by staff working with her;
- efforts should have been made to "sell" this approach to her by all professionals;
- funding should have been available via commissioners for this approach without unreasonable barriers if she expressed interest in this option;
- commissioners should support and encourage the development of residential facilities that will work with more complex substance use disorders including those with cognitive impairment.

4.2 Using the Mental Capacity Act

Although residential rehabilitation is probably the best option for her, realistically, the key question is whether Adult N has the mental capacity to take the decisions which will keep herself safe. This question was explicitly raised by the Police: *In January 2019, the police received a report from Adult N's support worker that she had disclosed a serious assault by her partner…However, Adult N had told her support worker that she did not want any contact with the police. Her partner was arrested and denied the offence. As Adult N refused to engage with police this was not progressed and was unable to be pursued as a victimless crime. She was allocated to a DVO for safety planning and referred into MARAC. At this point the police raised concerns regarding her mental state and capacity as a result of a brain injury. This was discussed at MASH and it was agreed that as the support worker had a good relationship with Adult N, she would action appropriate safeguarding and referrals.*

Another IMR highlights that Mental Capacity Assessments were completed around decision making in terms of managing her money but that: *there could have been more completed regarding other areas in her life….*

Braye and Preston-Shoot in their report *Learning from SARs* (2017) comment that: *'Reviews continue to uncover missed opportunities for mental capacity assessment and best interests meetings and decision-making. Assumptions are made about individuals having capacity. Reviews also continue to express concern that an individual's autonomy and self-determination is privileged to the exclusion of a duty of care, expressed in respectful challenge, curiosity and discussion regarding that individual's choices and the potential consequences of their decision-making. The evidence suggests that practitioners continue to find the Mental Capacity Act 2005 difficult to understand and implement'*[3]

As a result it is important to consider whether there were gaps in the use of the Mental Capacity Act in this case. Adult N's mental capacity was considered at a number of points:

- A capacity assessment was undertaken with regards to her relationship with her partner, prior to the timeframe for this review. On that occasion she was "found to maintain capacity".
- In February 2019 adult social care "considered" that she did have the mental capacity for a decision about her finances.
- In May 2019 Adult N went for cognitive testing. During this Adult N's ambivalence about competing her hepatitis C treatment was discussed, and it

was “confirmed” that she had capacity for decisions about her physical health treatment.
- In June 2019 she was “felt” to have the capacity to make a decision to stop support calls.
- In July 2019, a mental capacity act assessment was requested regarding her finances. Later in July her capacity regarding continued drug use was explored.
- In November 2019 Adult N was assessed as lacking capacity to manage her finances.

On the other hand, it is noted in one of the IMRs that her capacity for lack of attendance at the hospital was not assessed formally. *Given her diagnosis of head injury and substance misuse it may have been appropriate to formally assess her capacity to attend the vascular and neuropsychology secondary care referrals… and of the need to document in medical notes how capacity has been considered when a vulnerable adult does not follow an agreed medical plan.*

(It is interesting to note, as a side issue, the different phrases used to describe the “assessment” of her capacity. She was *found to maintain* capacity, *considered*, *confirmed* and *felt* to have capacity. This does obscure the nature and adequacy of these capacity assessments.)

The starting assumption with the Mental Capacity Act must always be that an individual has capacity, until there is proof that they do not.[4] However, as the Code of Practice also states: *it is important to carry out an assessment when a person’s capacity is in doubt.* [5] Adult N’s history of abuse suggests that it is reasonable to question whether she had the mental capacity to maintain her safety. As one of the IMRs comments: (Adult N’s drug use disorder was): *a factor in her vulnerabilities and that when she was under the influence there was concern around her capacity to keep herself safe.*

The Courts have *recognised that a person with an impairment of the mind or brain may lose capacity due to the overbearing influence of a spouse, relative or “friend”* e.g. A Local Authority v A*[2].*[6] The effects of alcohol or drug use count as an impairment of the mind or brain.

An article from the Landmark Chambers comments that: *Where there is a legal wrong, there should be the potential for a legal remedy. And if the vulnerable person does not have the capacity to protect themselves against being the victim of a legal wrong, it seems right that a public authority can legitimately intervene to create a breathing space to allow the individual time and headspace to make his or her own decisions as to whether to continue to be subject to a legal wrong.* [7]

Consideration was given to the use of the Mental Capacity Act at several points in the care of Adult N. However, it seems reasonable that there should have been further assessments of Adult N’s mental capacity, with regard to her ability to maintain her safety from abuse by others. This was specifically supported by two of the IMRs. Practitioners need to be reminded of this approach with individuals subject to abuse.

In making these assessments, it is important to remember that people who are dependent on drugs or alcohol are covered by the Mental Capacity Act. The fact that they appear to be choosing to use drugs does not mean that they are really exercising choice in that or other areas of their life.

Stage 1 of the two-stage test of mental capacity requires proof that the person has an impairment of the mind or brain.[8] These impairments include *the symptoms of alcohol or drug use*.[9]

The second stage tests whether a person can:
1. understand information about the decision to be made, or
2. retain that information in their mind, or
3. use or weigh that information as part of the decision-making process, or
4. communicate their decision. [10]
(NB As per the "York Judgement", the practice promoted in Newcastle is to reverse these two stages and to ask the stage 2 questions first, and then ask if any inability is due to an impairment or disturbance of the mind or brain.)[11]

A chronic, dependent drug user might not meet any of these four criteria. For example, a drug user with cognitive impairment might not meet either of the first two criteria. However, with many drug users the more relevant issue may be the third criteria: can they *use* information in a decision-making process. The MCA Code of Practice provides a useful parallel for the situation of the dependent drug user. The Code says: *a person with the eating disorder anorexia nervosa may understand information about the consequences of not eating. But their compulsion not to eat might be too strong for them to ignore.*[12] [13]

This is a situation that will be commonplace with many dependent drug users: their compulsion to use drugs means that they are unable to use information that they are given about the impact of their dependency, even if they understand and retain it. The Teeswide Carol SAR talks about the need to look at a dependent drinker or drug user's "executive capacity" as well as their "decisional capacity". Can someone both take a decision and put it into effect (i.e. use the information)? This will necessitate a longer-term view when assessing capacity with someone like Adult N

Assessing capacity in dependent drug or alcohol users is complex and should not be subject to simplistic judgements. Decisions may require time, multi-agency discussion and professional challenge.

The Code of Practice supports this stating that: *Information about decisions the person has made, based on a lack of understanding of risks or inability to weigh up the information, can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else.*[14]

In addition, it should be remembered that the Code of Practice comments that:
2.11 There may be cause for concern if somebody:
• repeatedly makes unwise decisions that put them at significant risk of harm or exploitation...These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation…[15]

Even if Adult N did have the capacity to make decisions about her safety, care and treatment, the Code suggests that professionals seeing her repetitive behaviour should certainly have explored what lay behind this pattern.

No-one can be certain whether further assessments of Adult N's capacity would have changed outcomes for her. However, as one of the IMRs said: *this case can be used in training to encourage appropriate documentation of capacity...*

4.3 Addressing her cognition

Adult N appears to have had cognitive damage due to a past serious accidental head injury, other accidents, seizures and abuse. She had memory difficulties and would be a non-attender at hospital appointments, appointments with professionals and other support offered. During the period of the chronology a number of assessments and professional contacts were focused on her memory. These included trying to get a neurology / memory clinic assessment of her cognition and assessment of a possible seizure. Therefore, understanding her brain function was a key issue in the response to Adult N.

In May 2019, she underwent a cognitive screening. This appears to be the Mini-Mental State Examination (MMSE) on which she scored 21/30. A score below 24 on MMSE suggests dementia. In July 2019, another MRI scan confirmed her diagnosis of traumatic brain injury.

Action was taken as a result of this. Various agencies made adjustments to interventions to support her:

- Her Advocate identified the need for memory aids i.e. photos of workers to remind her who would visit her and provided her with written notes about areas worked on as an aid to memory.
- DWP adjusted its approach to Adult N in order to accommodate issues with her cognition.
- The brain injury is recognised as a reason for her vulnerability by the Police.
- The Substance Misuse Services and Domestic Violence Services offered flexible approaches to accommodate Adult N's cognition.
- Because she was falling frequently, a falls detector was being arranged.

More importantly, Adult N was referred for admission for an inpatient assessment in relation to a head injury. However, she needed to have abstained from street drugs for three months before the assessment could go ahead, which proved difficult to achieve. The assessment was hoped to determine the impact the brain injury was having on her decision making.

As with all of the work with Adult N, there is much positive practice with regard to her cognitive impairment. However, it does raise three questions.

Firstly, is a three month wait for Adult N to achieve abstinence from drugs viable? This is an almost impossibly high bar for someone like Adult N. Moreover, if her brain deterioration is due to something other than the brain injury, e.g. Alzheimer's, three months is a long time to wait before taking action and would allow further deterioration to occur. The lack of clarity on cognition is also going to impact on the decisions of

other agencies, for example, about her mental capacity. It is acknowledged that it is very difficult to accurately assess cognitive function in someone with a substance use disorder. However, Adult N's case suggest that there should be an agreed pathway for, or approach to, people where cognitive impairment is suspected but for whom diagnosis is challenging. Without an agreed approach the situation is likely to continue to deteriorate and legal protections will be harder to use.

Secondly, in much of the discussion around Adult N, cognitive impairment is equated to poor memory. This can be one feature, but it is important to remember that brain injury can also impair executive functioning and affect impulse control. The latter is particularly important in people with substance use disorders who are attempting to change behaviour.

Thirdly, the brain injury needs to be considered in mental capacity assessments. It is likely that this was the case with Adult N but the evidence in the IMRs is not specific.

The combination of drug or alcohol use dependency and cognitive impairment is one that has featured in a number of Safeguarding Adult Reviews e.g. the James SAR from Brighton[16], the Alan SAR from Sunderland[17] or the Tom SAR from Somerset.[18] It is important that local professionals are aware of both this overall problem and the nuances and challenges of its presentation.

4.4 Using other legal frameworks

This review has considered the use of the Mental Capacity Act with Adult N and it is clear that the Care Act was extensively used with her. It is also clear from the IMRs that Domestic Violence Protection Orders were used to protect Adult N. Due to the many complaints regarding the behaviour of Adult N and visitors, to her home, an Acceptable Behaviour Agreement was drafted, outlining what type of behaviour was expected in terms of her Tenancy Agreement.

Two other legal frameworks that could have been considered are:

- The inherent jurisdiction of the High Court to intervene to protect vulnerable individuals with mental capacity.
- A Partial Closure Order under the Anti-social Behaviour, Crime and Policing Act 2014.

The inherent jurisdiction of the High Court is a doctrine of the English common law that a superior court has the jurisdiction to hear any matter that comes before it, unless a statute or rule limits that authority or grants exclusive jurisdiction to some other court or tribunal. The Mental Capacity Act 2005 replaced the inherent jurisdiction of the High Court in the case of mentally incapacitated people. However, the High Court has gradually extended the use of the inherent jurisdiction to the group of vulnerable adults who possess capacity but still require protection for certain reasons. Considering whether the use of inherent jurisdiction would have been helpful in the case of Adult N would require legal advice and significant discussion. However, it does remain a possible option in a situation where a capacitated person was subject to abuse.

The Partial Closure Order would have imposed a court order that restricted who could enter a property, e.g. excluding all but Adult N and key professionals from the property. In that Act "anti-social behaviour" means:

"(a) conduct that has caused, or is likely to cause, harassment, alarm or distress to any person,
(b) conduct capable of causing nuisance or annoyance to a person in relation to that person's occupation of residential premises, or
(c) conduct capable of causing housing-related nuisance or annoyance to any person" [19]

Therefore, this power could have been used to protect Adult N and the neighbours who were impacted by the visitors to her property.

This is not a simple solution. It needs to be enforced and consideration needs to be given to whether the imposition of the order might force Adult N to spend more time at her abuser's property. Nonetheless, it needs to be acknowledged that this is one possible approach to her situation.

4.5 Level of housing support offered

At a meeting in October 2018 agencies came together to consider suitable housing for Adult N. *It was agreed that sheltered accommodation would be the better option in terms of keeping her safe. Adult N wished to remain in the relationship with her Partner and so there was an increased risk if Adult N was offered an unsupported tenancy, that the Partner may move into the property.*

At the time of her death and for the previous 15 months she lived in sheltered accommodation which had self-contained flats. Staff were on site Monday to Friday, working the hours of 9 to 5. The site had secure door entry using a fob to access the building and was monitored by CCTV.

Despite these controls, people were still able to access Adult N's flat and caused problems to her neighbours: particularly out of working hours. This suggests the need for a property with a higher level of support: perhaps 24-hour on-site staffing. The author is unclear whether such property is available locally; it is also unclear whether, as with the partial closure order, this might have made the situation more difficult by driving her out of the property. Nonetheless, again it is a route for consideration.

4.6 Multi-agency management and escalation

The overall impression from the IMRs is that there was good multi-agency management around Adult N. Indeed, one IMR goes as far as to say that: *This case can be used as an example of good multiagency working in…safeguarding training.*

Another IMR says that: *Adult N was discussed on multiple occasions within the MARAC and Safeguarding Adults Procedures, allowing for good information sharing between partners regarding Adult N's vulnerability. Planning was reviewed and actions implemented to reduce risk presented to Adult N…The case highlights positive joint planning between a range of agencies when it became apparent that Adult N was at increased risk from exploitation.*

Another comments that: *the worker consistently worked within a multi-agency framework. She was in regular communication with social services, drug and alcohol agencies, the IDVA service and advocacy who were also involved with Adult N. This*

included email communication, joint appointments and attending strategy and safeguarding meetings.

It is interesting to note, therefore, that the Police IMR comments that: *There is little evidence of consistent multi-agency management in this case. However, this would appear to have been begun to be rectified…by the strategy meeting invite received on 11/02/2020.* This raises the question of whether all agencies were being involved and / or whether the right representatives, and at the right level, were attending meetings?

In the context of Adult N, the other element of multi-agency working that needs to be considered is escalation. In cases where there is serious risk and standard multi-agency frameworks are not eliciting change, there will need to be robust escalation pathways in place which can effectively challenge agencies to try more creative approaches to managing complex and potentially costly clients.

In Newcastle the route for escalating complex cases is via the Safeguarding Adults Unit. Safeguarding Adults Managers who work outside of the Safeguarding Adults Unit (Social Work Team Managers from the Adult Community Team, Learning Disability and Autism Team, Mental Health or Hospital Teams) can discuss complex cases with the Unit's Safeguarding Adults Managers asking for either advice/direction and/or asking that the case is Chaired by one of the Manager's within the Unit. Other professionals (from outside the Local Authority) can also seek advice/support about safeguarding cases via the Advice Line. There are some suggested parameters on what constitute a complex case, which includes someone is at risk from multiple perpetrators, but the starting point is the respective Safeguarding Adults Managers having a discussion about the particular case and agreeing next steps.

The IMRs do not indicate that Adult N was escalated in this way. Nonetheless, the Unit's work is publicised in both training and publications. It is important to ensure that all professionals are aware of escalation pathways and procedures for complex clients.

5. Other issues

This section addresses a number of other issues which are highlighted by the care of Adult N. These cover:

- Alcohol screening
- Recognising other impacts on her cognition
- Fire risk and smoking
- The role of the pharmacy.

5.1 Alcohol screening

It is an oddity of Adult N's presentation that there were very conflicting views about whether, or to what degree, alcohol was a problem for her. There is no sense that these varying perceptions caused any difficulties in her care. However, it is a reminder of the importance of robust alcohol screening processes to ensure that alcohol-related risk is identified and highlighted.

Best practice would ensure that the AUDIT alcohol screening tool[20] is routinely being used by all relevant professionals, whether in Primary Care, Mental Health Services or any other adult service. The Mental Health Trust IMR acknowledges that t*he alcohol AUDIT within the…electronic record was not updated contemporaneously to reflect changing patterns of alcohol use that was detailed within the progress (narrative) notes.*

In accordance with NICE Public Health Guidance 24, professionals working with the public need to be alert to the possibility of alcohol use disorders and should be routinely asking the AUDIT questions and using professional curiosity to explore this issue.

5.2 Other impacts on her cognition

The previous sections (especially 4.3) have commented extensively on her cognition. This has rightly been attributed to her pattern of head injuries. However, it is worth noting that two other issues may have been having an impact on her cognitive functioning: hepatitis C and diet.

Clinicians were aware that Adult N had been diagnosed with Hepatitis C and that she had initiated treatment previously but had not been compliant with this. This was revisited with her regularly. The IMRs reflect that in discussion with medical staff in May 2019, Adult N remained ambivalent regarding treatment for her Hepatitis and her capacity was considered regarding this and Adult N was deemed to maintain capacity. Clinicians discussed the effect of the condition on her mood, motivation and cognition. Ultimately, Adult N accepted referral for treatment and this was duly completed.

It is important that practitioners generally are aware that hepatitis C can impact on the cognitive functioning and mood of clients and that this should be considered when assessing them. Hepatitis C will make people tired, confused and, as some patients call it, "brain fogged". This may have impacted on her situation in the period in question and should have been a consideration in any assessment or risk assessment.

It is also worth noting that at one point Adult N admitted that she would suppress her hunger by drinking tea. This was discussed with her and she was advised to listen to her body and if she was hungry that she needed to eat. It was noted that Adult N

enjoyed going food shopping and often had large joints of meat in the freezer but that she would never eat them; instead, she would reminisce about enjoying her time as a family and cooking for her sons, rather than making herself a meal. Again, poor diet and nutrition can have an impact on both mood and cognitive function which needs to be considered at assessment.

5.3 Fire and Smoking

Adult N did not die in a domestic fire. Nonetheless, her death highlights the importance of two easily overlooked issues connected with this client group:

- the heightened risk of fire death in people with substance use disorders; &
- the prevalence of smoking and its related health harms and other risks.

The chronology is clear that she was a smoker and was advised to stop smoking by the Vascular Team at the Hospital. Smoking will have worsened her health and wellbeing including potentially worsening liver disease.[21]

However, the bigger risk was that of domestic fire. Professor Michael Preston-Shoot's recent *Analysis of Safeguarding Adult Reviews* examined 231 SARs from 2017-2019, 19 of the deaths involved were due to fire.[22] This highlights the importance of a focus on fire safety with vulnerable clients. It is important that all agencies include this in their risk assessment, flag the risks and, where possible, encourage harm reduction techniques including fire safety checks.

At points the Fire Service rated Adult N very high risk due to living alone, having mental health issues, being a heavy smoker, and having had a previous fire. In her previous property, in 2016, the Fire Service commented that she had had: *a fire caused by candles catching fire to curtains. Evidence of discarded cigarette butts on the floor throughout the bedsit, burn marks on the mattress which was only purchased in May 2016. Occupier admits she smokes in bed.*

In 2019, she had an accidental dwelling fire following unattended cooking, which led to damage and a smoke-filled kitchen and living room. By the time of her death the risk was graded as medium. However, in January 2020 there were still accidents happening including floods due taps running in the kitchen with the plug in, which, while not as dangerous as fire, does highlight a degree of inattention which could lead to a fire in other circumstances.

On the other side, it is positive that Adult N was subject to home safety checks by the Fire Service and was provided with appropriate advice and resources to help manage her risk.

5.4 The role of the pharmacy

Adult N was on a methadone script with a daily pick up from her local Pharmacy. This seemed to work well. There was evidence throughout the period under review of regular communication between Substance Misuse Services and the dispensing Pharmacy to monitor Adult N and maintain her in treatment and monitor risk. It was particularly positive that the Pharmacy was represented at the practitioners' workshop and actively involved in discussions of the case.

It is worth noting the Pharmacy's comments on the process: *Pharmacy did see Adult N on a daily basis, but this has been the first time we have been involved in the safeguarding process, I would like to highlight the importance that Pharmacies can play in the process to spot issues early on and to then contact agencies. Community pharmacy is often ignored in safeguarding situations however we are often the party that see the vulnerable patient the most and where patients present voluntarily. It would be beneficial to be aware of situations and be able to feed into cases.*
These comments appear to speak for themselves.

6. Key Learning Points

- Local services deserve praise for the response to Adult N. The work with her was characterised by positive, assertive, supportive multi-agency approaches. It is hoped that this level of support is on offer to all complex and vulnerable people with substance use disorders in the city.

- Despite this positive working, Adult N remained a vulnerable and complex individual. The central question raised by her care is: "what could services have done to protect someone who *appeared* to be repeatedly making unwise decisions which left her open to abuse and exploitation?" In particular, "what could have been done about someone who *appeared* to be choosing to continue to have contact with people who were abusing her?"

- Consideration was given to the use of the Mental Capacity Act at several points in the care of Adult N. However, the question (which was raised by at least two IMRs) remains – should there have been further assessments of Adult N's mental capacity, particularly with regard to her ability to maintain her safety from abuse by others?

- The review raises the question of whether a pathway into detoxification and residential rehabilitation should have been considered for her. It is likely that a detoxification followed by a period in a "dry" residential facility would have given her the best opportunity to escape the influence of the people who are abusing her, to allow her cognition to be assessed and to consider what she wants from her life in a supportive environment. This is a very difficult option to implement, but none of the chronologies or IMRs indicate that this was considered as an approach to addressing her situation.

- Adult N appeared to have cognitive impairment. The combination of drug or alcohol dependency and cognitive impairment is one that has featured in a number of Safeguarding Adult Reviews. It is important that local professionals are aware of both this overall problem and the nuances and challenges of its presentation.

- The requirement that someone with a substance use disorder must achieve three months sobriety to access Memory Services seems to be a significant barrier to care. The consequent lack of clarity on cognition is going to impact on the decisions other agencies, for example, about her mental capacity. It is acknowledged that it is very difficult to accurately assess cognitive function in someone who is currently using drugs or alcohol. However, Adult N's case suggests that there should be a locally agreed pathway for, or approach to, people where cognitive impairment is suspected but for whom diagnosis is challenging.

- Other possible frameworks that could have been considered in keeping Adult N safe were the inherent jurisdiction of the High Court or a Partial Closure Order under the Anti-social Behaviour, Crime and Policing Act 2014. These may not have turned out to be the right answer for her needs; but they remain options that professionals can and should consider.

- Adult N's care raises the question of whether she needed sheltered accommodation with a higher level of support: perhaps 24-hour on-site staffing. It is unclear whether such property was available locally; it is also unclear whether, as is also true of the partial closure order, this might have made the situation more difficult by driving her out of the property to ensure she can continue contact with her partner. Nonetheless, again it is a route for consideration.

- There was good multi-agency working around Adult N. But the question was raised as to whether all relevant agencies were being involved and / or whether the right representatives, and at the right level, were attending meetings?

- In the specific context of Adult N, the other element of multi-agency working that needs to be considered is escalation. In cases where there is serious risk and standard multi-agency frameworks are not eliciting change, there may need to be robust escalation pathways in place which can effectively challenge agencies to try more creative approaches to managing complex and potentially costly clients. In Newcastle the route for escalating complex cases is via the Safeguarding Adults Unit. The IMRs do not indicate that Adult N was escalated in this way. It is important to ensure that all professionals are aware of escalation pathways and procedures for complex clients.

- In accordance with NICE guidance, services should be using the AUDIT alcohol screening tool to identify and record the level of alcohol related risk. This provides a standardised and readily communicated way of talking about alcohol related harm.

- Adult N is a reminder that services need to have a focus on fire safety and smoking cessation with this client group.

- The potential of the Pharmacy to be an ally in safeguarding because of their close relationship with some people needs to be considered.

7. Good practice

As this report has already said, the work with Adult N was very good across the range of agencies that worked with her. In particular, the author would want to highlight:

- The work of her Independent Advocate whose skills and knowledge were evident throughout his involvement and who contributed positively to the SAR.
- The quality of the Pharmacy / Substance Misuse services link and the positive approach taken by the Pharmacy are worthy of note.
- The Domestic Violence focused outreach from the Changing Lives Domestic Abuse Women's Intensive Support Worker highlights the benefit from intensive longer-term support for women with multiple and complex needs.
- Substance Misuse Service outreach to Adult N is also a model of good practice.
- The DWP's willingness to adjust its approach to Adult N in order to accommodate issues with her cognition is worthy of note.

8. Recommendations

A. The Public Health Team who are responsible for commissioning Substance Misuse Services should provide assurance that pathways into detoxification and residential rehabilitation are considered and are available for complex clients like Adult N.

B. The Safeguarding Adults Board should ensure that guidance or protocols are available to support professionals to consider the use of the Mental Capacity Act in the context of vulnerable people's ability to maintain their safety from abuse by others.

C. The Safeguarding Adults Board should ensure that there is training on working with individuals who have both substance use disorders and cognitive impairment. This should include recognition that cognitive impairment is not just about poor memory but that it can also impair executive functioning and affect impulse control.

D. The Safeguarding Adult Board should work with local agencies to agree a local pathway for, or approach to, people where cognitive impairment is suspected but for whom diagnosis is challenging.

E. The Safeguarding Adult Board should ensure that awareness of less commonly used legal powers such as the inherent jurisdiction of the High Court or a Partial Closure Order under the Anti-social Behaviour, Crime and Policing Act 2014 is disseminated more widely so that they may be considered, where applicable, in work with vulnerable clients.

F. The Safeguarding Adult Board should consider whether there is sheltered accommodation that can provide a high level of support, perhaps 24-hour on-site staffing, to people who are at risk of exploitation and abuse from others.

G. The Safeguarding Adult Board should continue to ensure that professionals are aware of and use escalation pathways and procedures for complex clients.

H. The Public Health Team should ensure that all frontline services are aware of, and are able to use, robust alcohol screening tools such as the AUDIT tool to identify and record the level of alcohol related risk for clients.

I. The Public Health Team and Safeguarding Adult Board should seek assurance that frontline services have a focus on smoking cessation and fire safety with this client group.

J. The Safeguarding Adult Board should consider the potential of the Pharmacy to be an ally in safeguarding because of their close relationship with some vulnerable people.

Appendix 1 – Terms of Reference

At a meeting on 20 September 2021, the following key issues were agreed as being important and which should be considered within the SAR. The questions are intended as prompts to assist IMR Authors in evaluating and analysing agency involvement.

- Did your agency have any information to suggest that Adult N was being abused or neglected, including domestic abuse? If so, was this information appropriately acted upon? Was work in the case consistent with agency and NSAB policy and procedures for protecting adults at risk and other relevant local policies and procedures (including the NSAB Self-Neglect Practice Guidance)?
- What were the key points or opportunities for risk assessment and decision making in this case in relation to Adult N? Do the assessments and decisions appear to have been reached in an informed and professional way?
- Does it appear that all legal options, including seeking legal advice where appropriate, were explored to safeguard Adult N?
- Where relevant, were appropriate Safeguarding Adults Plans (protection plans), risk assessments or care plans in place and were these plans implemented? Were there any factors present that prevented these plans being implemented successfully? Had review processes been complied with?
- When, and in what way, were Adult N or her family's wishes, feelings and views ascertained, considered and acted upon? Did action accord with the views expressed?
- Was practice sensitive to any protected characteristics of Adult N?
- Were senior managers, or other agencies and professionals, involved at points where they could have been?
- Please comment on any aspects of the case or agency involvement that are examples of strong practice.
- Are there any particular features of this case, or the issues surrounding the case, that you consider require further comment in respect of your agency's involvement?
- What are the lessons from this case for the way in which your agency works to protect adults at risk and promote their welfare?
- Are there any aspects of NSAB policy and procedures that need to be reviewed as a result of this case?

Key questions specific to this case

- It is understood that Adult N had a history of heroin use, however, what role did other drugs and, particularly, alcohol misuse play in her life?
- Evaluate the steps taken to address her substance misuse?
- Was the Mental Capacity Act used sufficiently and appropriately with Adult N?
- To what extent was there a persistent, creative, and flexible outreach approach to working with Adult N?
- To what extent did consistent multi-agency management feature in her care?
- Adult N had hepatitis C – in planning her care was consideration given to the impact that this condition might have on her mood, motivation and cognition?
- Adult N had a serious head injury in 2012 and may have had further injuries to her head as a result of abuse and falls. Did agencies consider the impact of this damage while developing care plans for her?

- Was the potential impact of her smoking on her health and safety considered and addressed?
- Was the impact of her diet, nutritional status and weight on her wellbeing considered?

[1] Preston-Shoot, M. (2020) Ms H and Ms I: Thematic Safeguarding Adults Review. Tower Hamlets SAB
[2] Residential Rehabilitation Working Group: drug and alcohol residential treatment services - recommendations - gov.scot (www.gov.scot)
[3] Braye and Preston-Shoot - Learning from SARs: A report for the London Safeguarding Adults Board - 2017
[4] MCA Code of Practice 2007
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[6] Decision making, mental capacity and undue influence: Do hard cases make bad – or least fuzzy edged - law?[1] - Landmark Chambers | Barristers Chambers London
[7] Decision making, mental capacity and undue influence: Do hard cases make bad – or least fuzzy edged - law?[1] - Landmark Chambers | Barristers Chambers London
[8] Mental Capacity Act 2005 Code of Practice (4.11)
[9] Mental Capacity Act 2005 Code of Practice (4.12)
[10] Mental Capacity Act 2005 Code of Practice (4.14)
[11] https://1f2ca7mxjow42e65q49871m1-wpengine.netdna-ssl.com/wp-content/uploads/2021/11/Mental-Capacity-Guidance-Note-Capacity-Assessment-January-2022.pdf
[12] Mental Capacity Act 2005 Code of Practice (4.22)
[13] See also: Clough B. - Anorexia, Capacity, And Best Interests: Developments in The Court of Protection Since The Mental Capacity Act 2005 - Medical Law Review, Vol. 24, No. 3, pp. 434–445. (Clough Identifies three cases regarding anorexia that went before the Court of Protection. In each case it was decided that the person with anorexia nervosa did lack capacity.)
[14] Mental Capacity Act 2005 Code of Practice (4.30)
[15] Mental Capacity Act 2005: *Code of Practice 2.11*
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