Safeguarding Adults Review (SAR) Executive Summary on the death of Person D

This Review has been commissioned by the Independent Chair of the Leicestershire and Rutland Safeguarding Adults Board (L&R SAB), following a decision by the Case Review Group (CRG) and in accordance with the Care Act (2014) that this case met the criteria for a Safeguarding Adult Review (SAR).

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March 2022

1. Opening Paragraph

There is a long journey of trauma, illness and addiction that led to Person D self-neglecting in his adult life. Agencies that worked with Person D and Person E tried hard to keep them engaged but this was not always possible. There is key learning and associated recommendations that the SAB can now take forward to enhance and improve agencies' responses to people who find themselves in a self-neglect cycle. The Reviewer would like to thank Person D's family and Person E for their contribution to this report. In addition, thanks to all agencies and individual practitioners who contributed to the report. It is hoped that the learning from this SAR will improve practice moving forward when working with adults at risk who are self-neglecting.

2. Circumstances Leading to the Review

This case relates to the death of Person D who lived with his friend Person E. Person D was found deceased by paramedics.

3. Background

Person D had a background of trauma, suffering a serious road traffic accident in his teens requiring hospitalisation and developed an addiction to opiate medication. He was bullied at school and his girlfriend was murdered. Over his adulthood he developed addiction to prescribed opiates, street drugs and alcohol.

In the year leading up to his death, Person D's health was failing with decompensated liver failure secondary to alcohol misuse and was placed on a Do Not Attempt Cardiopulmonary Resuscitation (DNRCPR) to which his mother, his next of kin, was in agreement.

Person D lived with Person E who slept on the sofa, and he also had substance and alcohol addiction. Person E and Person D had been friends all of their adult lives.

They had a complex relationship and considered themselves to be carers to each other.

Person D was self-neglecting and various health and social care services were offered to him in the year running up to his death. He had variable engagement and often refused services. At the start of the Covid-19 pandemic, services for housing support and addiction support became virtual.

Person D and Person E continued to meet in the flat with groups of friends during lockdowns and it was during this period that various safeguarding concerns were raised in that Person E posed a risk to Person D both financially and sexually, neither allegation was accepted by Person D and Person E. In addition, due to Covid-19 breaches and presence of anti-social behaviour (ASB), the Police attended on a number of occasions where advice on compliance with Covid-19 regulations was given.

As part of the review, the SAB considered the impact of both Person D and Person E's ethnicity on their experience and identified no significant impact.

4. Methodology

The case met the criteria set out in Section 44, Safeguarding Adults Reviews, of the Care Act 2014, namely, that there is reasonable cause for concern about how the SAB, members of it or other

persons with relevant functions worked together to safeguard the adult, and an adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

The Panel agreed on the methodology and timeline for review. Agencies involved completed chronologies of their involvement with Person D and Person E, including some analysis. These were merged and used to produce a multi-agency chronology. An Independent Reviewer was appointed, and Key Lines of Enquiry were developed, followed by Individual Management Report (IMR) or Learning Summary Report (LSR), depending on the level of involvement by each agency. Two reflective practice events were held for managers and frontline practitioners. In addition, two interviews were held with Person D's Mother and with Person E to get their perspectives and learning was shared with them.

5. Key Lines of Enquiry (KLOE)

1) **Cuckooing / Criminal Exploitation**
   Research and establish details of any previous concerns about cuckooing and whether there were any current indicators as reference was made to Person D being stalked. Were there missed opportunities to protect Person D from Criminal Exploitation / Cuckooing?

2) **Therapeutic services**
   Where there is comorbidity between substance/alcohol misuse and mental health, are services joined up enough to assess and treat the comorbid needs? Should agencies be considering a more joined up approach to individuals who present with both substance/alcohol misuse and mental health difficulties?

3) **Professional Curiosity**
   a) Were there missed opportunities to explore the relationship between Person D and Person E, in particular when there were allegations of abuse from Person E to Person D? The narrative that Person E was a positive influence on Person D did not appear to change in light of the new information.
   b) Should a carer's assessment have been undertaken for Person E?

4) **Mental Capacity**
   Were there missed opportunities by agencies to assess Person D's mental capacity?

5) **Safeguarding**
   Were there missed opportunities to raise a safeguarding alert and was this because agencies had not accessed or misunderstood the Threshold guidance to inform their decision?

6) **Consider the impact of COVID-19**
   Had Covid-19 not been an issue, would there have been more face-to-face contact for assessment purposes between Person D and agencies?

7) **Vulnerable Adults Risk Management (VARM)**
Were agencies clear on the VARM procedure and were there missed opportunities to start the VARM process earlier? Was VARM the right process or should it have been safeguarding?

8) **Confidentiality**
Were agency confidentiality processes followed, and did they seek consent to share information between Person D and Person E?

9) **Family Involvement**
Did Person E's assumed carer status dissuade agencies from seeking consent from Person D to involve family members and next of kin at key decision-making stages?

10) **Supervision**
Did practitioners seek supervision when it was appropriate to do so?

6. Key Events Within Time in Scope

During 2019 Person D was seen with assault injuries by his substance misuse worker but declined to disclose information due to fear of violence. Person D's health failed and he spent time in hospital. A DNRCPR was in place.

By 2020 a safeguarding alert was raised by the tenancy support officer (TSO) due to self-neglect and the possibility of stalking. Person D had a package of care in place and throughout Spring 2020 numerous concerns were raised directly to the allocated social worker by the care service provider, TSO and the community nursing service, relating to crowds of people in his flat taking substances, depth of self-neglect and care workers being prevented from entering the flat.

Two VARMs took place but key agencies were not invited and therefore the risks known to Person D were not adequately explored. By the time of the second VARM a safeguarding alert had been raised by neighbours in regard to alleged sexual and financial abuse by Person E to Person D. The allocated social worker did not meet directly with Person D due to Covid-19 guidance and relied on care workers being the eyes and ears of the interagency partnership, though they were often refused entry by Person D. Additionally, care workers were also concerned that Person E was always present and may have been exerting control over Person D. Eventually 8 weeks after the safeguarding allegation raised by neighbours, a Section 42 enquiry was initiated. This was two weeks before Person D died.

7. Conclusions

Cuckooing

Though the criminal definition of cuckooing was not met there was a risk as defined by the LLR SAB procedures and therefore a safeguarding enquiry should have been undertaken as early as February 2020, instead the VARM continued. Person D was not protected from risk of abuse and the issues of

self-neglect and having capacity to make unwise decisions clouded agencies' judgement to assess the risk of cuckooing under the appropriate process – a Section 42 enquiry under the Care Act 2014.

Therapeutic services

Neither Person E nor Person D met the criteria for dual diagnosis. When referrals were attempted for support for Person E's paranoia symptomology and Person D's low mood and anxiety, the Thresholds to mental health services are designed to prevent access until substance/alcohol misuse is managed. There were no recommendations to make for this KLOE.

Professional Curiosity

There was lack of professional curiosity regarding the nature of the two men's relationship by all agencies and Person E's carer status was never recognised or assessed. As Person E was not seen as a carer, the caring stress that he was experiencing was not explored and the relationship between Person E and Person D became more volatile. We will never know if a Carer's Assessment would have alleviated some of the carer stress and thereby improved their relationship, but it is a question for this SAR to reflect upon.

Mental Capacity

Throughout the scoping period, Person D had fluctuating capacity due to his alcohol and substance misuse, added to this the deterioration in his health may have indicated that there was some cognitive impairment as early as January 2020 when he had reached the stage of end-of-life care.

Formal capacity assessment was undertaken once when assessing Person D's care and support needs by adult social care. When dealing with self-neglect and comorbid substance and alcohol misuse, only the substance misuse and ambulance services have built into their system a regular review of mental capacity. For all other agencies there is reliance on staff recognising when it is necessary to review capacity. A number of agencies in their IMRs stated there were missed opportunities to assess Person D's capacity.

Safeguarding

There were numerous missed opportunities to raise an Adult Safeguarding Enquiry under Section 42 of the Care Act 2014 in the two months leading up to Person D's death, as identified by the ASC IMR author. There was an accumulation of concerns raised by the care agency and the Community Nurses direct to the Social Worker. These were dealt with day by day but there was no standing back to take an overview of whether this accumulation was due to self-neglect, criminal exploitation, or coercive control and eventual abuse in relation to Person D by Person E.

The analysis shows that self-neglect concerns were considered via a VARM process. However, safeguarding adult abuse concerns, apart from two alerts, were not considered as safeguarding. The self-neglect narrative was dominant and the abuse narrative in essence subsumed by it.

Evidence of agencies actively using the Thresholds Guidance can only be found within two agencies during the scope of this review.

In conclusion, Person D was effectively not safeguarded because incidents of abuse were not investigated under the correct procedures – i.e., Section 42 of the Care Act 2014.

Consider the impact of COVID-19

In the year preceding Person D's death, England entered two periods of lockdown. As a result, services to both Person D and Person E were restricted. Both the Community Nursing Team and Medacs Healthcare, a homecare service, continued to offer a face-to-face service; however, all other services became virtual. In conclusion, Covid-19 continues to be a reality in present day working regardless of restrictions being lifted by the Government on 16th July 2021. In terms of assessing alleged adult abuse, there is no substitution for seeing a vulnerable adult face-to-face to assess concerns.

Vulnerable Adults Risk Management (VARM)

Once agencies had identified that there was significant risk of death due to self-neglect, a VARM should have been called. In Person D's case, this should have occurred in January 2020 not April 2020.

In conclusion, the analysis shows that the first VARM was called too late and, by the time of the second VARM, the Threshold for initiating an enquiry under Section 42 of the Care Act 2014 had already been reached.

Confidentiality

All agencies should formally record in line with their procedures that there is consent to share confidential information with others, including friends who provide aspects of care. This was not the case for most of the agencies who took implied consent as permission to discuss Person D in front of Person E.

The fact that Person D and Person E shared a mobile phone no doubt caused difficulties for agencies to effectively ensure confidentiality. The potential for mobile phones to be used as a mechanism for coercive control was not considered by any of the agencies. There is learning for SARs from domestic abuse research of women and men being coercively controlled via the mobile phone.

In summary, implied consent is a lower standard than informed consent and, in terms of safeguarding, agencies should aim to achieve informed consent that is recorded in notes at every contact when risks are known.

Supervision

There is evidence in the information presented in the merged chronology and through IMR and LSR submissions that all frontline practitioners involved in this case had access to supervision and in some agencies group supervision for complex cases.

In regard to ASC, though supervision was accessed by both Social Workers, some safeguarding concerns were not discussed in a timely fashion or not at all. There is obvious learning for individual practitioners and this has already been addressed by agencies.

8. Good practice identified by Agencies

Community Nursing

Compassionate care was provided to Person D, where appropriate information was shared in light of Person D's identified vulnerability with other agencies especially in regard to raising concerns for safeguarding. Mental capacity was assessed and actions taken in line with his best interests, i.e., when Person D refused a service, telephone contact was made regularly with him to encourage engagement with his medication regime.

Substance Misuse Services

Support was provided to Person D's mother and Person D by recovery workers when he was in hospital. There was good liaison between hospital and the community recovery team ensuring there was no interruption in his prescribed substance misuse medication on discharge. The substance misuse Prescribing Doctor liaised with Person D's GP surgery to discuss the risks of their prescribing Benzodiazepines and Person D's continued alcohol use.

When the Recovery Worker could not gain contact with Person D, they liaised with the community Pharmacy to check on his wellbeing.

GP Practice

The GP practice can evidence good communication between interagency partners by the Named GP.

Housing Support

The TSO deployed his activity with a high level of commitment to helping Person D meet his basic needs. The TSO proactively shared information with multiple involved agencies and facilitated joint visits with Adult Social Care to encourage better engagement with Person D and took Person D to GP appointments and visited him in hospital. Good practice in terms of a commitment to working together was evident.

Acute Hospital Services

Mental Capacity assessment was undertaken at appropriate times. Person D's behaviour though challenging on occasion was respectfully challenged. There was effective working with the substance misuse service.

Ambulance Services

Mental Capacity Assessments were undertaken at every contact with Person D.

Care Provider

The provider was proactive in raising its concerns with the allocated social worker and made contact with the pharmacy and police when appropriate to do so.

Adult Social Care

The involvement of the TSO could be considered exceptional in view of his proactive attempts to engage Person D and Person E. He was very responsive to all requests for joint visits to carry out assessments under the Care Act 2014 and Mental Capacity Act 2005.

The Student Social Worker maintained good communication with all partner agencies making numerous referrals to support Person D in his care and support needs. Face to face contact by the student social worker occurred with Person D on 6 occasions and demonstrated a strong commitment to her professional values in all encounters with Person D.

9. Interagency Recommendations

	Recommendation
1.	Once allegations of abuse linked to either cuckooing or criminal exploitation emerge, a strategy discussion between key agencies followed by a Section 42 Care Act 2014 enquiry should commence.
2.	The SAB should review its VARM guidance within the SAB procedures against latest research and good practice. In addition, there should be clear links to self-neglect guidance, to ensure practitioners are aware that with self-neglect comes heightened vulnerability to the risk of criminal exploitation.
3.	The SAB should consider ways to raise awareness amongst professionals and practitioners to ensure the following learning is shared: • In this SAR the self-neglect narrative became dominant leading to agencies not considering in a timely fashion abuse issues. • The VARM did not make significant progress or change for Person D and therefore the VARM review process should have occurred, this did not happen in Person D's case • Accumulating concerns in relation to this SAR were a feature, which should have been seen as a risk factor for people who self-neglect to be vulnerable to abuse or exploitation. • The learning should highlight that in co-dependent relationships mobile phones have the potential to become vehicles for coercive control and that learning from Domestic Abuse research should be incorporated into adult safeguarding practice. • Consideration of involving the family in the VARM process was not discussed with the adult at risk. Research has shown that, in self-neglect cases subjected to the SAR process, families were over involved or under involved. • Not all providers were aware of escalation processes when they felt the response from ASC was not robust enough. • The importance of accessing the Threshold guidance should be reiterated with all agencies in order to ensure that timely safeguarding concerns are referred in at the appropriate time.
4.	The SAB should consider reviewing the VARM guidance against recommendations in the Overview Report to take on board good practice around assessing risk in self-neglect, fluctuating capacity and impaired executive functioning. The SAB should then evaluate the use of the guidance within one year.

5.	All carers should be offered a Carer's Assessment in line with the Care Act 2014 to support them in their caring role. This should not preclude people in a co-dependent relationship due to substance or alcohol misuse. Risks and benefits of the co-dependent relationship can be examined as part of the assessment process.
6.	All agencies should formally record in line with their procedures that there is consent to share confidential information with others including friends who provide aspects of care. However, if safeguarding concerns are present then consent to share information is not needed.
7.	Where there is Anti-Social Behaviour and a case is open to the Joint Action Group (JAG), it would be beneficial to have mental health services provided by LPT, as appropriate, to discuss a case where mental health issues are present. In addition, where substance and alcohol misuse are also a factor involvement of Turning Point would also be beneficial. The interagency partners would benefit from being provided with guidance on the purpose of the JAG in relation to ASB and thus enhance frontline practitioners understanding of ASB.

Glossary

ASB	Anti-Social Behaviour
ASC	Adult Social Care
CBC	Charnwood Borough Council
CCG	Clinical Commissioning Group
CSP	Community Safety Partnership
DA	Domestic Abuse
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DOLS	Deprivation of Liberty Safeguards
ED	Emergency Department
EMAS	East Midlands Ambulance Service
GP	General Practitioner
IMR	Individual Management Review
JAG	Joint Action Group – part of Local District Safety Partnership delivery structure
KLOE	Key Lines of enquiry
L&RSAB	Leicestershire and Rutland Safeguarding Adult Board
LCC	Leicestershire County Council
LPT	Leicestershire Partnership NHS Trust
LSR	Learning Summary Report
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
MH	Mental Health
MHA	Mental Health Act
NoK	Next of Kin
PHE	Public Health England
PPN	Public Protection Notice
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
TSO	Tenancy Support Officer
VARM	Vulnerable Adults Risk Management
UHL	University Hospitals of Leicester NHS Trust