Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

SAFEGUARDING ADULT REVIEW
‘Andrew’

2022

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SAFEGUARDING ADULT REVIEW

Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

1. INTRODUCTION

1.1. Andrew was a 38-year-old white British man who was alcohol dependent. He lived alone in a flat. Andrew was described as a "really nice guy" who loved rock music, playing driving and flight simulation games and motorbikes. Andrew also loved cooking and would take photographs to show others the dishes he had created. Andrew worked in a warehouse and was very close to his mother and would take her shopping. Following the death of his mother in 2018, however, Andrew's consumption of alcohol increased. He had little contact with his family and he lost his job due to non-attendance.

1.2. Andrew had multiple health problems, including gastrointestinal bleeding and was attended to by ambulance crews on a regular basis. He had frequent stays in hospital and would discharge himself against medical advice. Andrew attempted alcohol detoxification without success. Multiple services were engaged with Andrew although the success of any interventions was short lived and contact with Andrew was often difficult. On 06/09/19 the Police were asked to gain access to Andrew's flat since other agencies had not been able to contact him since 30/08/19. Upon entering the flat they found Andrew to be deceased. The cause of death was upper gastrointestinal bleeding.

2. SAFEGUARDING ADULT REVIEWS

2.1. Section 44 of the Care Act 2014 places a statutory requirement on the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) 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

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

Arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –
a) identifying the lessons to be learnt from the adult's case, and
b) applying those lessons to future cases.

2.2. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

2.3. The purpose and underpinning principles of this SAR are set out in **Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board Safeguarding Adult Review Enquiry Procedures.**

2.4. All Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.5. This case was referred to the SAR Sub-group of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board in 10/19 and considered for a Safeguarding Adult Review at the meeting on 06/11/19.

2.6. The SAR Sub-group recommended that this case met the criteria for a SAR at a scoping meeting held on the 17/12/19, and the Independent Chair of the Board ratified this on 28/01/20.

2.7. The Safeguarding Adults Review was led by Patrick Hopkinson who is an Independent Consultant in Adult Safeguarding and who had no previous involvement with this case and no connection to the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board, or its partner agencies.

2.8. **The review**

This safeguarding adult review commenced on 25/09/20, a year after Andrew died. The process was delayed by the need to find an appropriate review writer and chair, after the original review writer became unavailable. The review took place during the time of the "second wave" of the coronavirus pandemic, the response to which had to be prioritised by partner organisations. This impacted on the availability of resources to apply to the process and extended the timescale for the review. The panel, practitioners, reviewer and chair and board manager all adapted to working remotely but the demands of other work, similarly affected by restrictions and organisational responses to the pandemic, also impacted on the reviewer and chair's capacity to complete the review within the nominal six month timescale.

3. BRIEF SUMMARY OF CHRONOLOGY AND CONCERNS

3.1. There were 309 recorded contacts by services with, or about, Andrew between 29/01/18 and 11/09/19, a period of 18.5 months. These referred to 105 discrete events, which had been recorded by agencies. These events involved direct contact with Andrew, hospital admissions, for example, or events about Andrew, for example, professionals' meetings, or attempts to arrange appointments with Andrew.

3.2. The following services were involved with Andrew during the time covered by the chronology:

- Staffordshire Fire and Rescue Service
- Dove Bereavement Service
- Community Drug and Alcohol Service
- West Midlands Ambulance Service University NHS Foundation Trust
- GP
- North Staffordshire Combined Healthcare NHS Trust
- Stoke-on-Trent City Council (social services and housing)
- British Transport Police
- Staffordshire Police
- Brighter Futures - Housing
- Royal Stoke University Hospital, part of University Hospitals of North Midlands NHS Trust

3.3. Due to the number of contacts with and about Andrew, this chronology will provide a summary and then will focus on key events.

Agency /organisation	**Direct contact with Andrew (eg face to face or by telephone)**	**Contacts between agencies or note entries made by agencies concerning Andrew**	**Failed contacts**	**Observations by SAR reviewer**
Staffordshire Fire & Rescue	2	3	0	
Dove (bereavement)	4	1	2	
Community Drug & Alcohol Service (CDAS)	7	54	11 plus 2 did not attend appointment	
West Midlands Ambulance Service University NHS Foundation Trust	16	1	6 refused to attend hospital	
GP (including out of hours GP)	8 This was mainly by telephone with out of hours GP service. Only one GP face to face visit (29/5/19)	38	3 plus 1 did not attend appointment. In addition, there is evidence of GP writing to Andrew, but Andrew was thought to be unable to read	
North Staffordshire Combined Healthcare NHS Trust (including the High-Volume Users Team and the Community Mental Health team),	11	33	6	There is an entry on 26/9/19, but this date is likely to be incorrect. The month may have been June 2019, not September) suicidal thoughts – CPN says will discharge from their care as problem alcohol related.

Stoke-on-Trent City Council (social services)	10	23	1	Andrew would not consent to social care referral
Stoke-on-Trent City Council (Housing)	6	21	0	
British Transport Police	2	0	0	
Staffordshire Police	8	6	0	
Brighter Futures (support worker)	13	27	3	
University Hospitals of North Midlands NHS Trust	9	0	0	• 5 Self discharged against medical advice. • 3 left without being treated. • There was a general pattern of Andrew being assessed to have the mental capacity to make the decision to discharge himself or to leave without treatment.

3.4. **Andrew**

3.5. Andrew was 38 years old when he died. He was a white British man, described by his support worker from Brighter Futures (an organisation supporting people with complex needs to achieve independence) as a "really nice guy" who loved rock music, motorbikes and playing driving and flight simulation computer games. Andrew also loved cooking and would take photographs to show others the dishes he had created. He lived alone in a flat but was very close to his mother and would take her shopping. Andrew worked in a warehouse but following the death of his mother in 2018, Andrew's consumption of alcohol increased and he lost his job due to non-attendance.

3.6. Andrew's relationship with his father and other family members was strained and they had little contact with him. Andrew was described as desperate for love and had met a woman on the internet who, it appears, was manipulating Andrew for financial gain. It is believed that at the age of nine years old, Andrew was sexually abused by a teacher and had been referred to Savana (the sexual violence abuse service in Stoke on Trent).

3.7. Andrew was known to be alcohol dependent, with a large daily intake. On 29/01/19 he was noted to drink two litres of vodka per day.

3.8. Andrew also had several health problems, which may have been related to his alcohol consumption. These included gastrointestinal bleeding (blood in his faeces and urine, blood in his vomit and black vomit) and abdominal and back pain. These systems were described by practitioners as not untypical for attendees at CDAS (Community Drug and Alcohol Service) appointments.

3.9. Andrew also had a C-difficile (Clostridium difficile) infection, first noted on 29/04/19 by Brighter Futures whilst Andrew was in hospital. This was treated with antibiotics but appears to have been occasionally confused with MRSA (Methicillin Resistant Staphylococcus Aureus: a hard to treat antibiotic resistant infection), leading to concerns that it was not safe to visit Andrew. These concerns seem to have impacted on the behaviour of some organisations more than others. For example, on 30/08/19, following a request by the High Volume Users (HVU) Team, the fire service carried out a fire safety check at Andrew's flat, which was also attended by a representative from Stoke on Trent City Council Adult Social Services. Andrew's C-difficile was noted and since spores could persist in a room for weeks or months the advice for those visiting was not to touch anything.

3.10. Andrew was self-neglecting, and services were aware of this. For example, in 10/04/19, Andrew was described as having "*lost a lot of weight with severe self-neglec*t". Andrew was not eating well, and sometimes said that he had not eaten for several days and was dehydrated. On 29/05/19, North Staffordshire Community Health Team received a call from Andrew's GP informing them that *'Andrew is self-neglecting, and his property is in a very poor state, there are flies and bodily fluids everywhere*". The ambulance service made 12 safeguarding adults referrals, six of

which were for an assessment of Andrew's self-neglect to Stoke on Trent City Council. No adult safeguarding enquiries or assessments of self-neglect were made.

3.11. **Service responses to Andrew**

3.12. Following the death of his mother, Andrew was referred to The Dove bereavement and loss counselling service by his Brighter Futures support worker on 24/10/18. Andrew did not attend appointments and so his case was closed.

3.13. Andrew did engage in alcohol rehabilitation for brief periods and frequently asked for a detox service. Efforts and offers were made. On 30/01/19, for example, the CDAS Recovery Coordinator and the Brighter Futures Support Worker made arrangements for detox preparation sessions and support for Andrew. The success of detox interventions with Andrew were, however, short lived. His last hospital stay for detox was in July 2019. On 17/07/19, the CDAS Recovery Coordinator visited Andrew in hospital and noted that Andrew felt motivated to remain alcohol free and *"felt differently than following his previous detox"*. Andrew was eager to engage with the Stoke Recovery Service. Despite this, Andrew discharged himself against medical advice the following day and on 26/07/19 was judged to be intoxicated during a visit by the Brighter Futures support worker. The CDAS Recovery Coordinator was actively involved with Andrew, frequently working with the Brighter Futures support worker to check on how Andrew was and to encourage his use of services.

3.14. Alongside this, Andrew also appears to have been trying to detoxify himself and was taken by ambulance to hospital on several occasions due to alcohol withdrawal (for example on 19/04/19 and on 27/05/19). These attempts may not all have been intentional. A person who is highly dependent on alcohol can rapidly show signs of withdrawal if they lack the money, or have been unable to leave their home, to buy alcohol.

3.15. In response to concerns about Andrew's self-neglect and the condition of his flat, on 17/05/19, Stoke on Trent City Council sent an "alleged breach letter" to Andrew. This was a routine action and advised that formal enforcement action could be taken if the situation did not improve. Andrew would not be evicted due to his needs and vulnerability and the aim was to encourage Andrew to engage with services.

3.16. This was effective since a deep clean was undertaken in June 2019 and a further deep clean, following a multi-disciplinary meeting, was completed in July 2019. These were paid for by the Stoke on Trent City Council housing service.

3.17. Despite this, the HVU team noted on 16/08/19 that during a risk assessment at Andrew's flat, made in the presence of the police due to concerns that Andrew may self-harm with knives, there was evidence of, "…*self-neglect including fly infestation, urine, rubbish, empty bottles (some with urine in them) and faeces despite flat being deep cleaned three weeks earlier. Fire risk, a bottle of spirits was knocked over on the floor and Andrew is a smoker, therefore increased risk of accidental fire*".

3.18. **Chronology of the last month of Andrew's life**

3.19. On 01/08/19, the Brighter Futures worker and an adult social services support worker visited Andrew to find that, according to a neighbour, he had gone out. The neighbour explained that Andrew had knocked on her door quite loudly the previous evening. The neighbour agreed to notify the Brighter Futures worker if she had any concerns about Andrew.

3.20. On 02/08/19, the neighbour told the Brighter Futures worker that she had not seen Andrew that morning or the previous night. A SoTCC housing officer told the Brighter Futures worker that she had visited Andrew on 29/07/19 and that he had been intoxicated but able to communicate. Later that day, Andrew telephoned the Brighter Futures worker and said that he had started drinking alcohol again and that his property was "*in a mess*".

3.21. On 06/08/19 and 07/08/19, the Recovery Coordinator from CDAS telephoned Andrew but received no reply.

3.22. On 12/08/19, the Brighter Futures worker and a SoTCC social worker visited Andrew. Andrew did not come to the door, but they spoke by telephone. Andrew said that he had backache but declined the offer of an ambulance. The two workers obtained keys for Andrew's flat from the housing department. This was to allow ease of access in an emergency and, whilst not normal practice, was considered necessary to help manage risks.

3.23. The same day a member of the HVU Team also visited and telephoned Andrew but received no answer.

3.24. On 13/08/19, Andrew was taken by the ambulance to the Royal Stoke University Hospital after being found by a member of the HVU Team, "*lying on the sofa, drinking vodka and sitting in faeces. The patient was intoxicated, agitated and aggressive. Andrew was deemed to lack capacity due to condition, hypotension and hypothermia, and intoxication*". A safeguarding referral was completed which stated that Andrew was found, "*lying on sofa in his own urine and faeces, just drinking, rotting food all over. vomit, faeces, bottles of alcohol on the floor. flies all over*". SoTCC made the decision to deal with this as part of Andrew's case management rather than to proceed to a safeguarding enquiry.

3.25. Andrew was reviewed by the Alcohol Liaison Team in hospital and admitted to the Acute Medical Unit. He was then transferred to a short stay unit. Deprivation of Liberty Safeguards (DoLS) were placed on Andrew to prevent him from leaving, which were to expire on 18/08/19 and a DoLS referral to SoTCC was completed on 14/08/19.

3.26. A member of the HVU Team visited Andrew in hospital with the SoTCC social worker on 14/08/19. Andrew was described as not able to retain information. He stated that he was not concerned that he could have died, and he appeared passive as to whether he lived or died. Andrew seemed to be confabulating and was hypothermic, which was noted to indicate potential Wernicke's Syndrome. Andrew said that he wanted to leave the hospital but was assessed not to have the mental capacity to make this decision.

3.27. The HVU Team member and the social worker discussed Andrew with the alcohol liaison nurse, who shared concerns about Andrew's mental capacity to make decisions to self-discharge. When sober Andrew had always been deemed to have capacity following any stay in the Royal Stoke University Hospital. When sober, Andrew had no apparent mental health needs and was motivated towards recovery but quickly started drinking again.

3.28. The HVU Team member and the SoTCC social worker also discussed fire hazards in Andrew's flat and the infection control procedures that were required when visiting Andrew due to his C-difficile infection. Both posed potential risks to other occupants in the same block of flats. They discussed a plan to re-house Andrew in another flat, and whilst this would not resolve the risks regarding his alcohol use, smoking or fire, the HVU Team member and the social worker judged this to be the best option and that it would reduce risks. They also considered that whilst Andrew's relationship with his father had previously been good, Andrew now had little contact with him due to his father's physical health problems.

3.29. The HVU Team member and the SoTCC social worker discussed the potential discharge plan for Andrew and the social worker suggested a discharge to a place of safety and then the involvement of the enablement team. A multi-disciplinary team meeting of the all the services involved was to be organised.

3.30. Andrew was judged to lack the mental capacity to consent to the involvement of the HVU Team and would be visited again the next day for a further discussion about this.

3.31. On 15/08/19 the HVU Team member visited Andrew again in hospital and spoke to the alcohol liaison nurse. Andrew would not be medically fit until 18/08/19 (a Sunday) and would be reviewed by the Alcohol Liaison team on 19/08/19 (a Monday). The DOLS (Deprivation of Liberty Safeguards) would remain in place until 18/08/19 but could be reviewed at any time. They discussed the discharge plan and the plan for an MDT meeting and agreed that this would be best option.

3.32. On 16/08/19 and 17/08/19, Andrew was assessed to lack the mental capacity to discharge himself but on Sunday 18/08/19 upon expiry of the DOLS, Andrew discharged himself against medical advice and concerns about his physical health ("*blood picture still deranged with Magnesium low, liver profile out of range and CRP high. Informed that the Consultant saw him yesterday and deemed him to have capacity*"). Andrew was assessed to have the capacity to make this decision and declined an offer to see the liaison psychiatry team before he left. SoTCC was informed that Andrew had self-discharged.

3.33. Andrew was visited at home on 19/08/19 by two members of the HVU Team and the social worker. They met Andrew outside who said that since leaving hospital that day had had "*a couple of drinks*" and was going out to buy a television and alcohol. Andrew consented to the HVU team working with him. Andrew was aware of the risks of purchasing more alcohol and the impact of this upon his physical health. Andrew had asked for support with his mental health when he was in hospital but now refused this and appeared to have the mental capacity to make this decision. Andrew then left but appeared unkempt, with dirty clothes and what appeared to be faeces on his shoes.

The HVU notes were that, "*Andrew continues to be at high risk of self-neglect – however has the understanding that his lifestyle choices will impact on this*" and that "*He remains at risk of accidental death due to poor choices*".

3.34. On 20/08/19 the HVU Team completed a risk assessment which identified the following:

- Self-harm in the past. Police have attended previously to remove a Stanley knife from Andrew.
- Self-neglect. Staff have observed fly infestation, urine and faeces in his property. Andrew has required hospital admission due to neglecting his health, and he has had C-difficile and remains at risk from infection. When intoxicated Andrew neglects his nutritional needs.
- Suicide. Andrew states he has had suicidal thoughts in the past, no current plans, but does not care if he dies.
- Harm from others. Andrew is potentially vulnerable to harm from others due to alcohol impeding his decision making.
- Substance misuse. Andrew is alcohol dependant and uses this as a way of coping. He has spilt alcohol and there is a fire risk.
- Fires or arson, due to unkempt nature of property. Andrew smokes
- Disengagement. Andrew has a history of being difficult to get hold of when intoxicated.
- Physical health or medical conditions. Substance misuse causes Andrew's physical health to become unstable warranting hospital admission.

3.35. A Multi-disciplinary team meeting/ Multi-Agency Meeting was held on 23/08/19, at which a plan was made to discuss a potential "Stop the Clock" exercise with the NSCHT Patient Safety Team. A "Stop the Clock" meeting would have reviewed the methods used to engage Andrew so far, considered what had worked well and what had not, and agreed a way forward between the agencies working with Andrew. Subsequently, a meeting was held to discuss a "Stop the Clock" meeting the day before Andrew was found dead. During the process of this review, agencies acknowledged that Andrew was found in crisis situations and much of the work with Andrew was as a response to this rather than to prevent the crises from happening.

3.36. On 27/08/19 a member of the HVU team contacted Andrew who was unwell and stated, "*I am in a bad way*". Andrew agreed to go to hospital after vomiting blood but wanted to stop treatment and return home. The GP notes recorded that Andrew had a "*gastric bleed*". Andrew self-discharged from hospital against medical advice on 27/08/19.

3.37. However, on 28/08/19 Andrew telephoned for an ambulance with upper and lower back pain and upper abdominal pain. Andrew had black vomit (an indicator of internal bleeding but this time refused to go to hospital. Andrew became verbally aggressive and the ambulance crew notes record that Andrew, "*has been checked over by ambulance and they are happy to leave him here, he is deemed to have capacity"*.

3.38. On 29/08/19, Andrew telephoned the police to report a break-in at his home. The police attended and spoke to Andrew at the door but after further enquiries were told to go away by Andrew.

3.39. On 30/08/19 a joint SoTCC and Staffordshire Fire and Rescue Service visit to Andrew was made to complete a fire safety check. The concern was that Andrew often stubbed out cigarettes on the floor, which was also sometimes covered by, or close to, alcohol. Andrew was reported to be intoxicated. This was the last recorded contact with Andrew.

3.40. On 03/09/19, a neighbour telephoned the police stating that a man, who claimed to be Andrew's uncle was banging on Andrew's door and had removed the letter box with what appeared to be a screwdriver. Local neighbourhood officers were made aware of this.

3.41. CDAS, SoTCC and the HVU team had been co-ordinating between themselves to check on Andrew three times a week and telephone calls to Andrew were made without success. A welfare check was arranged for Andrew on 05/09/19 but due to staff illness this did not take place.

3.42. On 06/09/19, a member of the HVU Team asked the police to visit Andrew since he had not been seen by them for nine days. The police gained access to the flat and Andrew was found dead, lying upon his back on the settee in his hospital clothing under a duvet (there was no previous mention of Andrew being dressed in hospital clothes in any other contacts with him). The cause of death was described as natural and due to upper gastrointestinal haemorrhage.

4. THE EVIDENCE BASE FOR THIS SAFEGUARDING ADULTS REVIEW

4.1 The Local Government Association Analysis of Safeguarding Adult Reviews April 2017 – March 2019 section 3.4 "*Type of Reviews*" describes a number of "methodological" requirements and related shortcomings of SARs, which can be summarised as follows:

4.2 SARs should connect their findings and proposals to an evidence base. There is, for example, a considerable amount of practice guidance for how to work with people who self-neglect but few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.

4.3 SARs should be based on research. Over 50 Safeguarding Adults Boards have carried out SARs on the same set of circumstances on more than one occasion but have treated each discreetly. The SARs do not refer to each other, build on each other, or ask why it happened again.

4.4 SARs should be analytical. There is too much description and not enough analysis.

4.5 SARs should not shy away from difficult or sensitive topics. Few SARs engage in the legal and financial context of practice or decision making and should raise the impact of funding cuts, government strategy and reductions in services.

4.6 Consequently, this SAR will consider both the research and practice evidence for working with people who self-neglect in the context of alcohol and substance use. The SAR will also consider the findings of a review of a pervious death in similar circumstances to that of MP, which was undertaken by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board in 2017.

4.7 **Alcohol-use findings from safeguarding adults reviews**

4.8 The Alcohol Change UK July 2019 report, "*Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017*"; analysed 11 SARs and identified a number of themes common to all the reviews. These were:

- Non-engagement with services
- Self-neglect
- Exploitation of a vulnerable person
- Domestic and child abuse
- Chronic health problems
- Mental health conditions
- Traumatic events triggering alcohol intake
- Lack of family involvement

4.9 The Alcohol Change UK July 2019 report also identified several practitioner perceptions that affected the way that services responded to these themes:

- Behaviours were seen as personal choice
- The extent of alcohol consumption was underestimated
- Lack of service capacity
- Commissioning of services so that they are available and effective
- High thresholds for support and for safeguarding concerns
- Understanding of the Mental Capacity Act and legal literacy

4.10 The extent to which these themes and perceptions were present in Andrew's case will be considered.

4.11 **Self-neglect practice guidance**

4.12 In addition to using a large quantity of alcohol, in the last few years of his life, Andrew was self-neglecting.

4.13 Self-neglect can be defined as, "*the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecter and perhaps even to their community*" (Gibbons et al, 2006, p.16). Of especial relevance to Andrew, whose mother's death preceded his increase in alcohol use, the loss of a loved-one is one of the two most common experiences cited by individuals who self-neglect (the other is being a victim of violence) (Lien et al, 2016). Self-neglect is one of the ten categories of abuse and neglect specified in the adult safeguarding sections of the Care Act statutory guidance.

4.14 There is extensive research into, and guidance on, working with people who self-neglect. For the purposes of this SAR, it is sufficient to focus only on a summary of this guidance. Readers keen to explore the research basis for this guidance will find several of the publications listed in the bibliography to be of value.

4.15 The guidance is that practice with people who self-neglect is more effective where practitioners:

- Seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience
- Work patiently at the pace of the individual, but know when to make the most of moments of motivation to secure changes
- Keep constantly in view the question of the individual's mental capacity to make self-care decisions
- Communicate about risks and options with honesty and openness, particularly where coercive action is a possibility
- Ensure that options for intervention are rooted in a sound understanding of legal powers and duties
- Think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks
- Work proactively to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals.

4.16 In order to do this, the following approaches should be used:

- History taking. Explore and ask questions about how and when self-neglect started
- Be proactive and identify and address repeated patterns of behaviour
- Try different approaches, use advocates (of all kinds, including friends, formal advocates for particular functions including Care Act advocates and community, citizen and peer advocates) and concerned others, raise concerns, discuss risks, maintain contact, avoid case closure
- Ongoing assessment and review of mental capacity.

4.17 **Repeated hospital admissions and contact with services**

4.18 Andrew attended the Royal Stoke University Hospital nine times in the period covered by this chronology. Andrew left the hospital three times before being treated and self-discharged against medical advice on five occasions. Previous Safeguarding Adults Reviews (for example, that of Ms H and Ms I, London Borough of Tower Hamlets, 2020) have identified that repeated emergency department hospital admissions (and in Andrew's case frequent attendances) are a potential warning sign of escalation in an adult's vulnerability (Jarvis et al, 2018) and that, for some adults at risk of abuse, hospital admissions may provide the only opportunity for safeguarding interventions to be made (Boland et al, 2014). These interventions should be made on a multi-agency and are more effective if they involve the vulnerable adult and their family as well as professionals.

4.19 Hospital admissions can also provide an opportunity for change: they can allow reflection, reconsideration and the engagement of other agencies and the use of different approaches and interventions (Boutin-Foster et al, 2005; Gersons, 1990).

4.20 **Self-neglect, mental capacity and freedom of choice**

4.21 All the contacts with Andrew took place within a policy context that emphasises choice, independence and personal control and which forms part of an overall neo-liberal Government led approach to adult social care and welfare (Ward et al, 2020).

4.22 Safeguarding Adults Reviews (amongst others Adults B and C, South Tyneside; Mr I, West Berkshire and W, Isle of Wight) have increasingly focused on the challenges of practicing in a way which balances the principles of freedom of choice and self-determination with the duties, public expectations and moral imperatives of public services. These take place within a legislative context that includes the Human Rights Act 1998[1], the Care Act 2014[2], the Mental Capacity Act[3] and the Mental Health Act 1983.

4.23 At the intersection of all these factors is the question of the extent to which adults should be left by public services to behave in a way that is objectively detrimental to their health and wellbeing or which threatens their lives. More fundamentally it is question of prioritising freedom of choice or prioritising protection from harm. The guidance on working with people who self-neglect helpfully challenges the either/ or nature of this question by asking practitioners to consider:

4.24 Is a person who self neglects really autonomous when:

a) They do not see how things could be different.
b) They do not think they are worth anything different.
c) They did not choose to live this way, but adapted gradually to circumstances
d) Their mental ill-health makes self-motivation difficult.
e) They have impairment of executive brain function.

4.25 Is a person who self neglects really protected when:

a) Imposed solutions do not recognise the way they make sense of their behaviour.
b) Their 'sense of self' is removed along with the risks.
c) They have no control and no ownership.
d) Their safety comes at the cost of making them miserable.

4.26 **Decisional and Executive Capacity**

4.27 The extent to which a person who self neglects can put whatever decisions they make into effect should also be considered. In Andrew's case there were concerns about his ambivalence and passivity. During his hospital admission between 14/08/19 and 19/08/19, Andrew was described as, "*passive as to whether he lived or died*". Whilst the Mental Capacity Act does not explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice.

4.28 There is also growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation) which in turn impacts on mental capacity. Of relevance is that, compared with control groups, people with frontal lobe damage caused by alcohol use and traumatic experiences:

- Are significantly slower and less accurate at problem solving when it involves planning ahead.
- Persisted with riskier behaviours for longer and were less responsive to negative outcomes.
- Were no different when identifying what the likely outcome of an event would be.

4.29 As a result, people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening.

4.30 Significantly, these cognitive deficits are unlikely to be detected using the verbal reasoning tests frequently used in mental capacity assessments. Andrew had brain scans on 27/04/19 and on 14/07/19, which identified that his brain structure had changed in a manner that was consistent with a history of excessive alcohol consumption (Generalised cortical atrophy and prominent generalised involutional changes: evidence that Andrew's brain had shrunk). No further tests were conducted, and it does not appear that these structural changes were operationalised into an understanding that they might result in any functional changes, which in turn could impact upon Andrew's mental capacity to make decisions about his care and treatment and to put these decisions into action.

4.31 **The Care Act 2014 and self-neglect**

4.32 Section 1 of the Care Act states that, "*The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's well-being*". A definition of well-being is provided (see appendix 2) but with relevance to Andrew, it is sufficient to note that well-being includes personal dignity (including treatment of the individual with respect); physical and mental health and emotional well-being; and suitability of living accommodation.

4.33 Section 9 of the Care Act (2014) states that where it appears to a local authority that an adult may have needs for care and support, the authority must assess (a) whether the adult does have needs for care and support, and (b) if the adult does, what those needs are. This Care Act duty applies regardless of the authority's view of (a) the level of the adult's needs for care and support, or (b) the level of the adult's financial resources.

4.34 If an adult refuses an assessment, then under Section 11, the local authority is not required to carry one out unless there are concerns about the adult's mental capacity to make the decision to refuse the assessment or that they are experiencing abuse or

neglect. This includes self-neglect. There are other circumstances in which assessment must be made despite refusal, which are not relevant to this SAR.

4.35 The Care Act also empowers local authorities to meet urgent needs without an assessment (section 19(3)). This is a discretionary power and so does not have to be used but the reasons for the decision to use or not to use this power must be recorded.

4.36 Consequently, the Care Act makes provision to, and allows some flexibility in how to, promote the wellbeing and meet the needs of adults who, like Andrew, self-neglect.

4.37 **Local findings from safeguarding adults reviews: "David"**

4.38 This SAR take place within the context of an earlier Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board learning review of "David" (2017). This learning review identified the following factors that influenced the circumstances which led to David's death.

- David's mother had died.
- David was unable to care for himself and having poor personal hygiene
- David had a high level of alcohol use and there was an over reliance by professionals on alcohol misuse to explain David's presentation
- Mental health service contacts with, and assessments of, David did not result in ongoing treatment including detoxification
- David had regular contacts with the ambulance service
- David was unpopular with his local community

4.39 The Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board learning review of "David" (2017) also identified a number of areas for improvement in practice as follows:

- Alcohol misuse should not be relied as the explanation for why an adult is presenting as they are. The wider context of the adult's life should be considered, including the reasons for the alcohol use and the presence of self-neglect.
- There is a service gap for multi-occupancy housing provision for under 55s and who are lonely and isolated.
- There is a need for creativity in supporting adults with extremely poor self-hygiene to make sure that they can access support e.g. church, self-help groups, voluntary services.
- Full documentation on case files is essential, allows others to really understand why decisions were made and trends in well-being.

4.40 **The local strategic context for effective work with people who self-neglect**

4.41 The effective implementation of the practice guidance and the local learning require a supportive strategic context. The guidance on working with people who self-neglect identifies that the policy, procedural and organisational environments that foster effective ways of working are likely to have the following characteristics:

- Agencies share definitions and understandings of self-neglect.

- Interagency coordination and shared risk-management is facilitated by clear referral routes, communication and decision-making systems.
- Longer-term supportive, relationship-based involvement is accepted as a pattern of work.
- Training and supervision challenge and support practitioners to engage with the ethical challenges, legal options, skills and emotions involved in self-neglect practice.

4.42 **The wider context**

4.43 It is generally well known that both social care and health care in the UK have faced years of financial constraints and cuts to funding since 2010 (if readers are still in any doubt about this, then an internet search using terms such as "austerity and social care" or "austerity and health care" will reveal a wealth of resources that do not need to be reproduced in this report).

4.44 Austerity has impacted on practice, particularly in social care, to the extent that decisions about who should receive services, and what the extent of those services should be, are influenced by financial constraints as well as need (for example, Olaison et al, 2018). Data for England in 2018/19 (Kings Fund, 2019) showed that whilst requests for social care services had increased by 6%, the actual number of people who received formal care packages had decreased by 2%. The learning review of David had previously identified there was a service gap in Stoke-on-Trent and Staffordshire for multi-occupancy housing provision for under 55-year-olds and that this had impacted on David's feelings of loneliness.

4.45 Whilst there was no direct evidence that resource restrictions impacted on the decisions taken by the professionals working with Andrew, there was evidence of a lack of suitable services for him. For example, on 07/06/19, the SoTCC Housing Officer proposed alternative accommodation for Andrew, but this was considered to be unsuitable due to access and not being on the ground floor.

4.46 During the course of this review, practitioners recognised that there was no residential rehabilitation service in Stoke on Trent and that over the past three years it had become increasingly difficult to obtain residential alcohol rehabilitation placements. Capacity in this area was noted to have disappeared as services were decommissioned, leaving a gap. NICE guidance is that inpatient and residential assisted withdrawal should be considered for anyone who regularly drinks over 30 units of alcohol per day (or who regularly drinks more than 15 units per day and has related mental and physical health problems or a cognitive impairment). Andrew was noted to have drunk two litres of vodka per day, which was equivalent to approximately 80 units of alcohol per day. Despite this, the hospital-based, rather than residential, detoxification was available in Stoke on Trent but does not appear to have been considered.

4.47 Consequently, two of the factors identified in the Alcohol Change UK report that might influence the perceptions and actions of practitioners, "*Lack of service capacity*" and "*Commissioning of services so that they are available and effective*", were present.

4.48 There is also a growing literature on the difficulties faced by men (Baker et al 2015), which include seeking help less often than women (Wang et al, 2013) and facing preconceived notions about their lifestyle, compliance with services and their ability to meet their own needs (see for example, Carson. 2011).

5. ANALYSIS

5.1 Using this research and practice evidence base it is possible to analyse the way in which the different organisations involved worked with Andrew.

5.2 Andrew, and the response of services to him, shared a number of characteristics with the cases identified in the Alcohol Change UK July 2019 report, "*Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017*". These were as follows:

5.3 **Non-engagement with services**

Between 29/01/18 and 11/09/19, there were 16 examples of unsuccessful single and multi-agency attempts to engage Andrew. These ranged from Andrew not attending pre-arranged appointments to Andrew refusing entry to his home and refusing to go to hospital. Despite this developing pattern and concerns about Andrew's health and welfare, there was no change in the way that services tried to engage Andrew, including adaptations to when, where and how Andrew was approached and by whom or consideration of the use of other legal powers such as application or the Court of Protection or the use of the High Court's inherent jurisdiction (Alcohol Change UK, 2020).

5.4 **Self-neglect**

There were 19 references to self-neglect between 10/04/19 and 05/09/19 plus three safeguarding referrals by West Midland Ambulance Service to Stoke on Trent adult social services for an assessment of self-neglect and five other requests for assessments. Andrew also asked for support on two occasions. An assessment of needs was begun on 19/07/19 and remained open until Andrew's death.

The assessment focused on Andrew's needs and how they impacted on his wellbeing. The assessment concluded that Andrew's needs were not eligible under the Care and Support (Eligibility Criteria) Regulations 2014 (section 13(7) of the Care Act 2014) for publicly funded care and support. The assessment recommended that Andrew be kept open for review and liaison with, and coordination of, the efforts made by other agencies to support him and that that he "*…takes full advantage of the help and support being offered by all the agencies*" working with him. Given the known extent of Andrew's self-neglect, his limited ability to care for himself and his history of not being able to take advantage of the services offered to him, this conclusion and recommendation appear overly optimistic.

Self-neglect, being unable to self-care and having poor personal hygiene also featured in the David learning review undertaken by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board in 2017. Implicitly, as identified by the Alcohol Change UK 2019 report, Andrew's, "*Behaviours were seen as personal choice*".

Consequently, the approach to Andrew seems to have been task orientated rather than aimed at *seeking to understand the meaning and significance of the self-neglect, taking account of the individual's life experience*. For example, there was *a lack of history taking* to understand Andrew's life and to place his current attitudes and behaviours in any form of context and to use this as a means for engaging with him. Efforts were made by the Brighter Futures support worker and a worker from the HVU Team to do this by developing a relationship with Andrew and discussing his relationship with his father, for example, but no further understanding was developed of Andrew's past and what might have influenced his current situation and the decisions he made.

On reflection, practitioners noted that in 2016, Andrew had complained of hearing loud music in nearby flats and had expressed a wish to move out of his flat. The noise complaint was investigated but neighbours reported that they did not hear such music. There does not appear to have been a further exploration of whether or not this music had been an hallucination or other form of cognitive phenomena which might have suggested that Andrew was developing mental health difficulties. Practitioners also noted that in early 2019 Andrew was working in a warehouse. At the time his flat was untidy but relatively clean. Andrew lost his job due to non-attendance as his alcohol consumption was increasing and his self-neglect increased following this.

5.5 **Exploitation of a vulnerable person**

There was little known about Andrew's social network and circumstances but there were some warning signs that he was being exploited. For example, on 05/03/19 Andrew wanted to speak to the police regarding problems with his neighbours who he said were constantly causing a nuisance. On 16/07/19, whilst in hospital Andrew made references to his girlfriend and her daughter, whom he chatted with online. Andrew said that he would need to move as they were going to come and live with him. On reflection, practitioners were concerned that Andrew may have been financially exploited in this relationship. On 03/09/19 the police attended following a report that a man, who claimed to be Andrew's uncle, was trying to gain access to Andrew's home.

5.6 **Domestic and Child abuse**

There was a suggestion that Andrew had been sexually abused as a child. There were few references to this and little exploration of how this and any other previous traumatic experiences might have contributed to Andrew's present situation.

5.7 **Chronic health problems**

Andrew had chronic health problems which included ultimately fatal gastrointestinal bleeding as a result of alcohol misuse and related health conditions and a Clostridium difficile infection.

5.8 **Mental health conditions**

Andrew was described as suffering from depression (29/01/18) and community mental health services attempted to engage him. On 15/09/18, Andrew was detained under s136 Mental Health Act by British Transport Police due to concerns that he was suicidal. Andrew was taken to the Harplands Hospital, a mental health service. On 10/04/19, there was a suggestion by the Brighter Futures worker that admission under the Mental Health Act might be useful and on 29/05/19 a Mental Health Act assessment was requested by Andrew's GP to facilitate the treatment of Andrew's physical health needs. The Mental Health Act, however, does not allow detention for physical health treatments. These contacts with mental health services also revealed difficulties in making assessments whilst Andrew was intoxicated.

Mental health service contacts and assessments that did not result in ongoing treatment, including detoxification, also featured in the David learning review undertaken by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board.

5.9 **Traumatic events triggering alcohol intake**

There was no exploration of the extent to which Andrew's earlier life had exposed him to traumatic events. Andrew's mother had died within the 12 months prior to the period covered by the chronology and it was believed that this had a detrimental effect on Andrew's mental health. The impact of this bereavement, or of other previous traumatic experiences (there was a suggestion that Andrew has been sexually abused in his childhood), upon Andrew's alcohol intake is difficult to measure using the available information. In 2018 there were attempts by Dove to offer Andrew bereavement counselling, but Andrew did not make use of these. There do not appear to have been attempts to explore why Andrew did not make use of this counselling and he was left to make contact again if he wished. The loss of a mother was also a feature in the David learning review undertaken by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board.

5.10 **Lack of family involvement**

Family involvement is a feature in both the Alcohol Change UK report of 2019 and in the guidance on working with people who self-neglect. There was some evidence of the involvement of Andrew's family and attempts to engage with them during the period covered by the chronology. Agencies were aware of Andrew's father, as evidenced by the liaison with him by the ambulance crew to obtain a key to Andrew's flat on 24/05/19; the SoTCC housing team manager encouraging Andrew to stay with his father for a few days whilst a deep clean of his property was completed on 28/06/19 and Andrew's discharge from hospital to his father's address on 03/07/19. All of these contacts were essentially transactional (i.e short-term and with a specific goal) rather than relational (i.e. long-term with more general goals) in nature. The only

exception appears to have been when a member of the HVU Team had a discussion with Andrew about his relationship with his father on 14/08/19. This does not appear to have led to further efforts to involve Andrew's father or to support the strengthening of Andrew's relationship with him. Consequently, in terms of the guidance on working with people who self-neglect, there little evidence of thinking *flexibly about how family members and community resources can contribute to interventions, building on relationships and networks*.

5.11 **Local learning**

5.12 As already noted in section 4.29, Andrew also shared a number of other characteristics with David, who was the subject of a previous review by Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board. Some of these characteristics were not explicitly identified by Alcohol Change UK in its 2019 metareview (the report only selected safeguarding adults reviews that included high levels of alcohol use and therefore this was an implicit rather than an explicit characteristic) and were:

5.13 **High level of alcohol use and over reliance on alcohol misuse to explain presentation**

5.14 The difficulties Andrew experienced were frequently ascribed to his excessive use of alcohol, a judgement that had been present previously in the learning review of David. The Alcohol Change UK 2019 report also identified that alcohol consumption was often underestimated but this was not the case with Andrew, whose alcohol consumption was recognised to be very much in excess of government guidelines. Perhaps consequently, alcohol use was considered to be the cause of Andrew's problems when it might have been more useful to consider it to be a consequence. For example, on 12/07/19 a SoTCC Senior Social Worker noted that when Andrew was abstinent from alcohol, he did not have care and support needs and therefore was not eligible for services. On 14/08/19, the HVU Team care records note that during a discussion with SoTCC, the Social Worker had commented that when Andrew was sober, no mental health needs were apparent. At a multiagency meeting on 18/07/19, attended by SoTCC Housing, Social Services and Brighter Futures, it was confirmed that Andrew would not be eligible for more than an enablement package since he "had capacity" when not using alcohol (the notes do not explain what this capacity was). This shows evidence for the presence of the "*High thresholds for support and for safeguarding concerns*" identified in the Alcohol Change UK report. There may also have been misapprehensions about responsibilities under the Care Act. Under the Section 9(1) of the Care Act 2014, the appearance of care needs is sufficient to lead to an assessment of needs and under Section 11, where there are concerns about abuse or neglect, an assessment must still be made irrespective of mental capacity.

5.15 **Regular contacts with the ambulance service**

Andrew had 16 contacts with the ambulance service between 02/03/18 and 28/08/19. On six occasions, Andrew refused to go to hospital and was judged to have the mental capacity to make this decision.

5.16 **Unpopularity with his local community**

5.17 Unlike David, Andrew does not appear to have been unpopular and there were few reports of any disturbances in which he was involved. Andrew's neighbours were concerned about Andrew and were supportive of the services trying to work with him.

5.18 Summary of the analysis of the research and practice evidence base

5.19 Considered in the light of both the Alcohol Change UK 2019 report and the review of David, Andrew's case cannot be considered to be unusual or unique and his circumstances further confirm the pattern already identified by Alcohol Change UK and by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board review of David. The significance of this is that the presence of this pattern of characteristics:

- non-engagement with services;
- self-neglect;
- exploitation;
- domestic and child abuse;
- chronic health problems;
- mental health problems;
- traumatic events triggering alcohol intake;
- lack of family involvement;
- high levels of alcohol intake and over-reliance on alcohol use to explain the adult's presentation;
- regular contact with ambulance services and
- unpopularity with the local community or concerned neighbours

5.20 Might be predictive of poor outcomes unless different approaches are taken. In consequence, services should consider how the presence of this pattern of characteristics might be identified in the future and how this might lead to interventions that result in better outcomes.

6. THE EXTENT TO WHICH PRACTICE WITH ANDREW WAS CONSISTENT WITH GUIDANCE ON WORKING WITH PEOPLE WHO SELF-NEGLECT

6.1 In addition to alcohol use, self-neglect and of the characteristics that suggest poor outcomes already discussed, the extent to which the services involved with Andrew applied the guidance on working with people who self-neglect, and the lessons learned from the review of David, in practice should be considered.

6.2 **The approach taken when working with Andrew**

6.3 There was considerable evidence of *working patiently at the pace of the individual*, with Andrew who was not pressured or persuaded unduly. This does not seem, however, to have occurred within the context of *knowing when to make the most of moments of motivation to secure changes.* Several efforts were made to do this. For example there was consideration of whether or not to discharge Andrew to alternative accommodation on 14/08/19 where he might be safer. Andrew had said that he no longer felt safe in his current accommodation. Another flat had been found for him in the same block, but Andrew no longer wanted to live in a block of flats with shared

internal areas and a communal door entry system. He wanted to live in a maisonette with his own front door. The plan to rehouse Andrew continued until his death.

6.4 **Exploration of legal options for working with Andrew**

6.5 There were attempts to *ensure that options for intervention are rooted in a sound understanding of legal powers and duties*. For example, the use of eviction procedures and the use of Deprivation of Liberty Safeguards to keep Andrew in hospital between 14/08/19 and 18/08/19, but these did not go far enough in depth (for example to use these in a coordinated manner with other agencies to support an identified goal for Andrew) or in breadth (for example, there does not appear to have been consideration of any other legal powers that might have supported change or prompted new interventions). Application to the High Court might have been productive. The case of London Borough of Croydon -v- CD [2019] EWHC 2943 (Fam), for example, shows that a chronic dependent drinker can be determined to lack the mental capacity to make decisions about their care.

6.6 **Adult safeguarding concerns and responses**

6.7 Eleven safeguarding concerns were made about Andrew between 02/03/19 and 27/08/19. SoTCC's records only identified six of these as safeguarding concerns. None of these led to safeguarding enquiries under Section 42 of the Care Act 2014.

6.8 The safeguarding concerns were raised predominantly by the ambulance service when they either took Andrew to hospital or judged that he had the mental capacity to refuse treatment. All the safeguarding concerns raised referred to Andrew's condition (that he was alcohol dependent; covered in faeces and blood; that he was self-neglecting) and the condition of his flat (unkempt, covered in mould). On 02/03/19 the crew also reported a concern that Andrew was being financially abused by the woman he had met on the internet, whom Andrew described as his girlfriend. The other safeguarding concerns were as follows:

6.9 On 19/04/19, the ambulance crew's safeguarding concern also reported environmental risks to other flats in the block and Andrew was taken to hospital. The response to this concern by SoTCC was to request notification from the hospital of Andrew's discharge.

6.10 On 20/05/19 and on 21/05/19 Brighter Futures support workers raised safeguarding concerns about Andrew. In response to this, a case was opened for Andrew on the SoTCC system.

6.11 On 21/05/19 the ambulance crew raised a safeguarding concern. At SoTCC, Andrew was now open to the Wellbeing Team. SoTCC's outcome following this concern was that Andrew was advised to attend the Royal Stoke University Hospital for treatment for his infection and to "get a referral for his alcohol misuse". The notes also record that whilst Andrew was an inpatient the Environmental Health team would be contacted, and efforts could be made to make his property more suitable to live in. Andrew, however, had refused to be admitted to hospital.

6.12 On 24/05/19 the ambulance crew raised a safeguarding concern due to Andrew's self-neglect.

6.13 On 12/06/19 Royal Stoke University Hospital raised a safeguarding concern since Andrew was self-neglecting.

6.14 On 03/07/19 the ambulance crew requested an assessment for self-neglect. Andrew was described in the SoTCC notes has having no care and support needs when detoxed from alcohol**.** No immediate further action was taken by SoTCC since a Multi-Disciplinary Team meeting had already been arranged for 09/07/19 and which SoTCC would attend to support any plans for Andrew to be rehoused.

6.15 On 22/07/19 the Police raised a safeguarding concern for self-neglect. The decision by SoTCC was that the criteria for a Section 42 enquiry had not been met since Andrew was receiving support form Brighter Futures and Andrew, "*was able to look after himself however he is choosing to drink alcohol*".

6.16 On 13/08/19 the ambulance crew raised a safeguarding concern due to self-neglect. A Section 42 enquiry was not considered to be appropriate, and instead Andrew's needs would be dealt with in case management.

6.17 On 27/08/19 the ambulance crew raised a safeguarding concern. This was closed on 28/08/19 since the Section 42 threshold was judged not to have been met. Andrew was described as an ongoing concern with an alcohol addiction and welfare checks were being completed three times a week. Andrew would be supported as much as possible whilst awaiting more appropriate accommodation and, *"…it would be disproportionate to progress to a section 42 as he is willing to engage with services if he is moved to alternative accommodation*".

6.18 On two occasions the criteria for a Section 42 enquiry was judged not to have been met but there is no evidence that consideration was given to making "non-statutory" enquiries. Section 42 of the Care Act sets of the circumstances in which a safeguarding enquiry must be made but these do not limit the circumstances in which safeguarding enquiries can be made. Even if the statutory criteria set out under Section 42 is not met, then "non-statutory" enquiries can still be made if there is a concern that an adult is at risk of abuse or neglect, including self-neglect. The duty of care and to manage risks remains regardless of the criteria in Section 42.

6.19 On other occasions, it would appear that the decision not to proceed with safeguarding enquiries was made because there was already ongoing work with Andrew. This represents an overly optimistic attitude to Andrews situation and a sense of false security that because multiple agencies were involved the outcome would be a positive one. It may also represent an unwillingness to use safeguarding processes to challenge and scrutinise case work.

6.20 There appears to have been a belief *that Andrew was able to care for himself when* he was not drinking. This indicates an *over reliance by professionals on alcohol misuse to explain Andrew's presentation* and a lack of consideration that there may be any underlying needs. It also suggests that Andrew's use of alcohol was a lifestyle choice

rather than recognised as a response to trauma and an addiction which could have a coercive and controlling influence on the decisions he made.

6.21 A characteristic of these safeguarding concerns is that they came from a variety of different sources. Whilst ambulance crews raised the most concerns (seven), Brighter Futures, the Police and the Royal Stoke University Hospital also raised concerns. Unfortunately, this diversity does not appear to have prompted any further scrutiny or consideration that the ongoing work with Andrew may not have been effective. Similarly, the eleven safeguarding concerns were reported over a period of five months and this frequency should have prompted further scrutiny.

6.22 Since no safeguarding enquiries were made following these concerns it is not possible to predict the extent to which safeguarding enquiries, if they had been made, might have resulted in different outcomes for Andrew. The purpose of an enquiry under Section 42 of the Care Act is to decide, "*whether any action should be taken in the adult's case and, if so, what and by whom*". Despite growing evidence from a variety of sources that Andrew's situation was not improving and despite concerns that Andrew was being financially abused, no enquiries were made.

6.23 This represents a failure in the safeguarding process. There is also a need to reconsider the relationship between safeguarding and ongoing case work. There were eleven missed opportunities, six of which were recorded as safeguarding concerns, for reconsidering whether the approaches being taken to support Andrew were working and to consider whether different approaches might be required to protect Andrew's life. These opportunities were not taken.

6.24 Given the discrepancy between the number of safeguarding concerns raised by partners and the number recorded as safeguarding concerns by SoTCC, is a need for SoTCC to review, with input from partners, the process and system for receiving and recording referrals.

6.25 Similarly, and in line with the findings from the review of David, the reasons for closing safeguarding referrals or the decisions made were not always clearly explained. Therefore, it remains that *Full documentation on case files is essential,* which, *allows others to really understand why decisions were made and,* to identify, *trends in well-being.*

6.26 **Multi-agency working with Andrew**

6.27 This was further compounded by there being little *proactive work to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals*. There was a multiplicity of organisations involved and a very considerable amount of inter-agency information sharing and communication. There was also evidence of follow up to ensure that messages had been received. Joint working, evidenced by joint visits was regularly practiced. Despite this, few interventions and interactions were coordinated at any level above that of individual case work. There were some attempts to *communicate about risks and options with honesty and openness, particularly where coercive action is a possibility,* but these took place outside of any intervention that might have capitalised upon them.

6.28 The extensive multi-agency working did not, however, include the use of multi-agency escalation processes. The SSASPB has an escalation procedure with graded steps for resolving professional disagreement, including where there are concerns about another professional's decision making, actions or inaction. This may be useful where professional challenge is appropriate or where urgent action is necessary to prevent further harm to an adult at risk. Stoke on Trent also operates a Multi-Agency Resolution Group (MARG), with a broad membership including SoTCC social services and housing; Staffordshire Police; mental health services, Staffordshire Fire and Rescue and Brighter Futures. The purpose of the MARG is to, "*provide early intervention/prevention using a solution focused, flexible forum in which to unblock barriers and empower practitioners to support adults who have or may have care and support needs across the city. This does not mean that an assessment under The Care Act has been completed, sufficient concern that the person MAY have care and support needs makes the referral appropriate*".

6.29 The majority of the practitioners involved with Andrew were unaware of the MARG despite working in organisations represented on it. Referral to the MARG may have facilitated a more coordinated and risk aware response to Andrew's needs, which may have led to more effective interventions. There is a need to ensure that practitioners are aware of both the board's escalation procedure and of the MARG and how to access and use them.

6.30 **Understanding Andrew's mental capacity to make decisions**

6.31 There was, however, extensive evidence of *keeping constantly in view the question of the individual's mental capacity to make self-care decisions*. Andrew's mental capacity to make decisions about his self-care, his use of alcohol, his health care and the need for treatment were frequently questioned and assessed but there was little multi-agency awareness of, and response to, repeating patterns and escalation. There was a tendency to consider each assessment of mental capacity as a discrete event and to only focus on Andrew's mental capacity operationally (i.e., Andrew's capacity to consent to a particular intervention) rather than strategically (i.e., in terms of consistency, fluctuation and of deeper questions than just whether or not Andrew would accept treatment at a particular time). Assessment of Andrew's mental capacity should also have taken place within the context of the effects of Andrew's long-term alcohol use, particularly since there were reports of confabulation, personality changes and occasional aggression.

6.32 The chronology includes references to at least 20 mental capacity assessments of which the following are a sample.

6.33 On 02/03/19, the ambulance crew assessed Andrew to have the mental capacity to refuse an abdominal assessment and to refuse to go to hospital.

6.34 On 19/04/19, the ambulance crew assessed Andrew to lack the mental capacity to refuse to go to hospital, after finding Andrew on the floor. Andrew said that he had been lying on floor for four days.

6.35 On 21/05/19 the ambulance crew assessed Andrew to have the capacity to refuse to go to hospital.

6.36 On 29/05/19 the ambulance crew spoke to Andrew about the Mental Capacity Act. Andrew then closed the door on them. The crew assessed Andrew to have the mental capacity to refuse treatment.

6.37 On 04/06/19 the ambulance crew assessed Andrew to lack the mental capacity to refuse treatment and took him to the Royal Stoke Hospital. Andrew appears to have left within an hour of arrival and without having been treated. Andrew was assessed to have the mental capacity to make this decision.

6.38 On 12/06/19, the ambulance crew assessed Andrew to have the mental capacity to refuse treatment.

6.39 On 06/07/19 the ambulance crew assessed Andrew to lack the mental capacity to refuse treatment and took him to hospital. On arrival, the Royal Stoke University Hospital assessed Andrew to have the mental capacity to refuse treatment and Andrew self-discharged.

6.40 On 10/07/19 due to Andrew's mental health state and living conditions (no furniture, bed, lying on floor with carpets soaked in urine) and despite his refusal, the ambulance crew took Andrew to the Royal Stoke University Hospital. Andrew stayed at the Royal Stoke University Hospital until he was assessed to have the mental capacity to make decisions about his health treatment and he self-discharged.

6.41 On 13/08/19, the ambulance crew found Andrew, "*lying on the sofa, drinking vodka and sitting in faeces. The patient was intoxicated, agitated and aggressive. The patient was deemed to lack capacity due to condition, hypotension and hypothermia, and intoxication*" and took him to the Royal Stoke University Hospital. Andrew stayed there under Deprivation of Liberty Safeguards until 18/08/19 when he self-discharged and was deemed to have the mental capacity to make this decision to leave the hospital.

6.42 On 27/08/19 Andrew was taken to the Royal Stoke University Hospital. He was described as intoxicated and said that he had vomited blood. On 28/08/19 self-discharged and was deemed to have the mental capacity to make this decision.

6.43 On 28/08/19 the ambulance crew noted that Andrew had upper/lower back pain and upper abdominal pain and black vomit. Andrew refused any assessments and was deemed to have capacity, became verbally aggressive and the crew left.

6.44 The results of the mental capacity assessments appear, to an extent, to have been influenced by whether or not Andrew was intoxicated to the point of unconsciousness and by his physical condition. There were three occasions on which Andrew was assessed by an ambulance crew to lack the mental capacity to refuse treatment and yet to have been assessed by the hospital to have the mental capacity to self-discharge the same day or the day after.

6.45 There was also some recognition of the need for a less task orientated approach to assessing Andrew's mental capacity. On 30/05/19, Andrew's GP requested that the Community Mental Health Team at the Sutherland Centre complete a mental capacity assessment since Andrew continued to decline medical assistance. It is unclear if this mental capacity assessment was carried out.

6.46 Other than this, there is little evidence that mental capacity assessments were made outside of contacts with the health service. This supports the Alcohol Change UK 2019 report finding about the influence of the "*Understanding of the Mental Capacity Act and legal literacy"* on practitioner perceptions and practice.

6.47 There was some recognition that Andrew's mental capacity might fluctuate. For example, on 01/06/19, a Brighter Futures Support Worker discussed this with an NHS 111 call handler. Most frequently, however, each assessment of mental capacity was made without regard to an earlier one and so no pattern was explicitly recognised.

6.48 **Case leadership and ownership of responsibility for meeting Andrew's needs**

6.49 More broadly, there was a lack of leadership in responding to Andrew's needs. The work was left largely to individual practitioners in Brighter Futures, CDAS and later members of the HVU Team who were in regular contact with each other, made joint visits to Andrew and worked with the other services involved.

6.50 In summary, some of the key components of effective practice with people who self-neglect were either not applied or were applied insufficiently.

6.51 **Facilitators of, and barriers, to effective practice.**

6.52 Some explanations for the way that services responded to Andrew were found during interviews and discussions with the staff who worked with Andrew:

6.53 **Understanding of Mental Capacity**

6.54 The reflections of practitioner and service representatives on the understanding of mental capacity in Andrew's case revealed the following. There was not a clear understanding, shared by all practitioners, about assessing mental capacity when Andrew was intoxicated. There was not a general understanding of the impact of addiction upon decision making. Practitioners discussed how decisions made under the influence of alcohol could be considered to have been made under duress or coercion and control. In this way, Andrew could have been assessed to have lacked the mental capacity to make decisions about his health and care needs and treatment whilst intoxicated. Andrew's dependence on alcohol could also have been considered to have a coercive and controlling influence on his mental capacity when he was sober. This approach is promoted by the Alcohol Change UK December 2020 report, "*Safeguarding Vulnerable Dependent Drinkers*".

6.55 Decisions about Andrew's capacity varied and this may have been a result of individual opinion as well as of Andrew's presentation and any fluctuation of capacity over time. Agencies tended to work in silos when a more joined up approach was needed for

Andrew. Many organisations were working with Andrew, but they were often working in isolation and were not always aware of the actions each were taking. An earlier multi-disciplinary meeting to bring all organisations together to formulate and implement a cohesive approach would have been helpful.

6.56 **Andrew's self-neglect, mental health needs and physical health needs were intertwined.**

6.57 Practitioners noted that Andrew's alcohol consumption may have masked other undiagnosed mental illnesses and that the challenges and difficulties faced by Andrew were considered to be matters of personal choice and lifestyle. For example, people who misused alcohol were recognised by practitioners to be frequently ambivalent about life and often did not feel that they had the mental energy to fix anything or change what appeared to be an inevitable outcome. Practitioners also identified that an assumption was made that the state of Andrew's flat was due to his alcohol consumption but in reality, the two may not have been so directly linked. Care should be taken to not make assumptions about adults with alcohol dependency.

6.58 As a result, little consideration was given to using any other agencies that might be able to support Andrew in a different way with the consequences of his self-neglect. Accordingly, the recommendation from the review of David that there is a *Need for creativity for people with extremely poor self-hygiene to make sure that they can access support e.g., church, self-help groups, voluntary services* also remains relevant.

6.59 Practitioners identified that whilst it was not typical of attendees at CDAS appointments to be vomiting blood, passing blood in their urine and dry retching, it was not a unique situation. The evidence of Andrew's deteriorating health condition was again considered to be an inevitable consequence of his alcohol consumption, which may have reduced sensitivity to the seriousness of it.

6.60 Despite the number of safeguarding concerns raised about Andrew, no safeguarding enquiries were made. It appears that the reasoning for this was influenced by the number of agencies involved with Andrew and the number of concerns raised. The decision was that Andrew would be best managed through on-going case work but the consequence of this was that safeguarding concerns were not linked together to spot patterns in, or escalation of, Andrew's health problems. In addition, there was a belief at SoTCC that Andrew was allocated to a social worker who was actively involved in Andrew's case management. The main contacts with Andrew were, however, by members of the Brighter Futures, CDAS and the HVU teams.

6.61 Practitioners were unaware of the Multi-Agency Resolution Group and did not know that it was a forum that they could bring cases to that were difficult and may need some extra impetus to manage.

6.62 **Good Practice**

6.63 There was intensive input by practitioners and especially by the Brighter Futures Support Worker and also by the CDAS Recovery Coordinator and by a member of the HVU team. They worked closely together, shared information and concerns, carried

out joint visits to Andrew, visited him a hospital ward and liaised with other professionals and teams.

6.64 The steps taken to complete the deep clean and facilitate the gas inspection were also evidence of good practice. It was not normal practice to undertake such cleans of a tenanted property, at a cost to the Housing Service.

7. CONCLUSIONS

7.1 **There was a lack of coordinated activity in understanding and responding to Andrew's situation.**

7.2 The agencies tended to work in silos. Even though there was evidence of joint working and communication at a practitioner level this did not translate into a more focused and coordinated multi-agency approach. The use of a multi-agency multi-disciplinary team approach had been suggested on 10/07/19 and a meeting was held on 18/07/19 in response to concerns about Andrew's deteriorating physical and mental health. This was attended by representatives from housing, adult social services and Brighter Futures. The outcome was that Andrew would only be eligible for an enablement package once he had been moved to more suitable accommodation since when not using alcohol he had capacity. Andrew's flat required another deep clean in addition to the one completed in June 2019 and Housing agreed to prioritise his move to more suitable accommodation to facilitate the provision of the enablement package. This meeting did not prompt recognition that, other than a move to new place to live, other approaches to support Andrew might be required to engage him more effectively.

7.3 No further multi-disciplinary meetings were held in response to the deteriorating situation until 23/08/19, just prior to Andrew's death. The outcome of any new approaches facilitated by multi-agency discussion and input to *work proactively to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals*, cannot be determined, but they may have led to a better formulation of Andrew's needs, a recognition of repeating patterns and how these could be better responded to. The first recorded risk assessment was made by the HVU Team on 20/08/19, although this was single rather than multi-agency.

7.4 **There was insufficient attention to mental capacity and choice and lack of exploration of Andrew's circumstances**

7.5 There was little contemporary exploration of Andrew's background, how he had come to be in the situation he was living in and what had led to his high intake of alcohol and his high level of self-neglect.

7.6 Andrew's mental capacity was assessed but there is no clear evidence that the impact of long-term alcohol use on mental capacity and decision making was recognised by the agencies who were working with Andrew. There is extensive research on the impact of life trauma and of alcohol use on the frontal lobe and associated increases in risk taking behaviour and impulsivity (see section 4.27 above and the Alcohol Change UK Report 2020, Safeguarding Dependent Drinkers which states, "*Many patients with frontal lobe damage are wrongly considered to have capacity, because*

in a simple assessment environment they know the correct things to say and do. When they need to act upon that knowledge in the complex setting of the real world they are driven by impulse and, therefore, can no longer weigh up options").

7.7 There was a recognition that Andrew was drinking excessively and self- neglecting, but this did not lead to any change in the way that services responded to him.

7.8 Andrew had an infectious illness, and this was used as a reason not to visit him on 07/05/19 and 29/05/19. There does not appear to have been exploration of how safe access might have been achieved and at the same time the ambulance service was still attending as necessary.

7.9 **There was a lack of escalation of concerns**

7.10 There was a lack of use, or absence, of escalation processes, including the use of the Safeguarding Board's own processes or referral to the MARG (Multi-Agency Resolution Group). Practitioners appeared to be unaware that the MARG existed. No comprehensive response to Andrew was created and no risk assessment was made until 20/08/19.

7.11 Legal literacy does not appear to have been employed to identify other approaches such as environmental health interventions or housing law interventions (except on 17/05/19 when proceedings to evict Andrew were begun) and to use these to create the potential for change.

7.12 Andrew's behaviours and the condition of his flat were assumed to be matters of life-style choice despite the evidence from research and other safeguarding adults reviews that, in the context of substance use and self-neglect, the concept of "life-style" choice is misleading at best and potentially dangerous.

7.13 **Safeguarding referrals were made but no action was taken**

7.14 Eleven safeguarding referrals were made about Andrew between 02/03/19 and 27/08/19. SoTCC had records of six of these identified as safeguarding concerns. None of these led to safeguarding enquiries under Section 42 of the Care Act 2014. These were missed opportunities for reconsidering whether the approaches being taken to support Andrew were working and to consider whether different approaches might be required to protect Andrew's life.

7.15 This represents a failure in the safeguarding process and indicates a need to reconsider the relationship between safeguarding and ongoing case work.

7.16 The local authority is the lead agency for adult safeguarding under the Care Act and must act when it has "reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)":

- Has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and

- as a result of those care and support needs is unable to protect themselves from the risk or experience of abuse or neglect.

7.17 Furthermore, the Care Act Statutory Guidance makes provision for non-statutory adult safeguarding enquiries (also known as "other" enquiries) and interventions where the "three-part test" is not met, but where there is sufficient concern that someone may come to harm. It is likely that Andrew met at least the criteria for a non-statutory adult safeguarding enquiry and that either this or a S42 enquiry might have been an opportunity to reconsider the extent to which the current interventions and approaches were proving effective. This in turn might have led to the use of different interventions and approaches to meet Andrew's needs or might have reprioritised the need for an assessment of Andrew's needs. Unfortunately, none of these opportunities were taken.

8. RECOMMENDATIONS

Domain 1: direct practice with individuals

The Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) should seek assurance that partner agencies are promoting trauma informed practice, particularly with people who use substances and self-neglect and that this should be reinforced through training sessions, learning events and one-to-one management meetings.

The SSASPB should seek assurances that repeat or re-occurring safeguarding concerns are routinely analysed, and patterns and escalation are identified and acted upon.

There should be further promotion of the role of "lead practitioner" particularly in complex cases. This would be the staff member with the best relationship with a hard to engage client. This role would lead on engagement and coordination and should not be limited to staff in statutory organisations but should be recognised by each partner as the lead worker.

Stoke-on-Trent City Council should identify how to improve its response to adult safeguarding concerns and how information is recorded, in the light of this Safeguarding Adults Review and the review of David (2017). This could include training and monitoring interventions supported by case audits and case discussions in one-to-one and team meetings.

Domains 2 & 3: Agency and interagency practice

Given the discrepancy between the number of safeguarding concerns raised by partners and the number recorded as safeguarding concerns by SoTCC, is a need for SoTCC to review, with input from partners, the process and system for receiving and recording referrals.

The Multiagency Resolution Group (MARG) which has been developed by Stoke on Trent City Council in partnership with Brighter Futures is seen as good practice and should be used as a forum to which practitioners can bring cases to that are difficult

and may need some extra impetus and coordination to manage them. SoTCC are to provide assurance that the MARG continues to function. SCC are to consider a formation of a similar forum to the MARG. All relevant partner agencies are to promote the existence and function of the MARG.

Domain 4: Board level

The SSASPB should use the themes identified in the Alcohol Change UK report, the review of David (2017) and this review of Andrew (2019) to revise or create new practice guidance for working with people who use substances and self-neglect. This guidance should be reinforced through training sessions, learning events and one-to-one management meetings.

The board should seek reassurance from relevant agencies that they have systems in place that identifies people for whom this report, the Alcohol Change UK report and the review of David (2017) is relevant; what service provision is available to them and the mechanisms that support them in gaining access to those services.

The SSASPB should seek assurance that the MARG is operating effectively and is being used appropriately.

APPENDIX 1: Wellbeing

Section 1(2) of the Care Act (2014) states that:

"Well-being", in relation to an individual, means that individual's well-being so far as relating to any of the following:

a) personal dignity (including treatment of the individual with respect);
b) physical and mental health and emotional well-being;
c) protection from abuse and neglect;
d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
e) participation in work, education, training or recreation;
f) social and economic well-being;
g) domestic, family and personal relationships;
h) suitability of living accommodation;
i) the individual's contribution to society.

APPENDIX 2: HUMAN RIGHTS ACT

All public sector bodies, whether or they are directly or indirectly funded by the UK Government have a duty under the Human Rights Act to discharge the State's positive obligations under the European Convention on Human Rights:

- Article 2 – to protect life
- Article 3 – to protect against torture, inhuman or degrading treatment
- Article 5 – to protect against unlawful interferences with liberty, including by private individuals

- Article 8 – to protect physical and moral integrity of the individual (especially, but not exclusively) from the acts of other persons

APPENDIX 3: MENTAL CAPACITY ACT

The Mental Capacity Act requires a three-stage test of capacity to make decisions:

1. Is the person unable to make the decision? i.e. are they unable to do at least one of the following things:
   - Understand information about the decision to be made, or
   - Retain that information in their mind, or
   - Use or weigh that information as part of the decision-making process, or
   - Communicate their decision (by talking, using sign language or any other means)

2. Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors such as alcohol or drug use?

3. Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to? Individuals can lack capacity to make some decisions but have capacity to make others, so it is vital to consider whether the individual lacks capacity to make a specific decision at a specific time.

APPENDIX 4: Literature review

The literature review was conducted in November-December 2020 using the following resources:

1. An internet search using Google to find open access journals and articles
2. The Royal Society of Medicine's on-line journals and related sources
3. The British Psychological Society's on-line journals and related sources
4. The Athens on-line journals and related sources

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