SAFEGUARDING ADULT REVIEW
OVERVIEW REPORT

in the case of

'ALISON'

December 2022

Acknowledgements

The coordination of this review has been assisted greatly by the SAR panel with their local, professional and organisational knowledge. It has also been assisted by the chronology authors in the work they undertook and analysis they provided of their agency.

The practitioners who attended the learning event are also thanked for their valuable contributions and discussion.

Version control

Version	Date	Changes
1	22/02/2022	First draft
2	30/05/2022	Second draft following circulation to panel initial feedback
3	21/06/2022	Third draft following SAR subgroup
4	08/08/2022	Recommendation 2 amended
5	11/10/2022	Changed from 'Sarah' to 'Alison'
6	16/11/2022	Amendments post WSAB
7 FINAL	23/12/2022	Amends at request of WSAB

TABLE OF CONTENTS

1. Introduction

1.1 This review focuses on the care and support afforded to Alison who was a person of 55 years of age when she died. Alison lived alone in her own home and had for some time suffered with mental ill health. This was thought to be exacerbated by Alison's use of alcohol.

1.2 Alison's struggle with her mental health and her use of alcohol was believed to have had an impact on her behaviour. Agencies were regularly involved with Alison for what was sometimes viewed as anti-social behaviour. Alison lived at an address that- had no access to utilities due to the poor state of the address and non-payment of bills for a protracted period of time.

1.3 Ultimately Alison was given a term of imprisonment linked to allegations of repeated anti-social behaviour. On her release from prison Alison initially moved to another area before returning to Worcestershire. In September 2021, when agencies had not had contact from Alison for some time police were asked to check on her address. Police found Alison deceased at the address.

1.4 In 2014 Alison had a primary diagnosis of Schizophrenia, with a secondary diagnosis of acute and transient psychotic disorders. When assessed in mid-August 2020, the diagnosis was a non-organic psychotic disorder.

2. Methodology and terms of reference

2.1 The purposes of a SAR are: -

- Learn from cases where there are clear concerns that agencies have not worked as well together as they might; and which demonstrate areas of practice that could have been delivered more effectively and additionally

- Consider whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented, and use that consideration to develop learning that enables the safeguarding adult partnership in Worcestershire to improve its services and prevent abuse and neglect in the future.

- Agree how this learning will be acted on, and what is expected to change as a result.

- Identify any issues for multi or single agency policies and procedures.
- Publish a summary report, which is available to the public.

2.2 The Worcestershire Case Review sub-group undertook a Rapid Review looking at the treatment, care and support that Alison had received and decided that the criteria were met for a proportionate Safeguarding Adult Review. Each agency identified as being involved was requested to provide information and chronology detailing their involvement. Practitioners who were involved with Alison's care were invited to take part in a reflective discussion event. The discussion from these events is reflected throughout the report.

2.3 Chronologies were provided by the below agencies :-

Worcestershire County Council Adult Social Care (WCC ASC)
Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT)
Herefordshire and Worcestershire Clinical Commissioning Group (HWCCG)
National Probation Service (NPS)
Worcestershire Acute Hospitals NHS Trust (WAHT)
West Mercia Police (WMP)
West Midlands Ambulance Service (WMAS)
Hereford and Worcester Fire and Rescue Service (HWFRS)
Onside – Independent Advocacy (OIA)
Wyre Forest District Council (WFDC)
Worcestershire Regulatory Services (WRS)

2.4 Terms of reference for the review were agreed. The terms of reference identified the focus of the review as between 1st January 2015 to the date of Alison's death 23rd September 2021.

The areas identified by the panel for consideration were:

- How well did organisations work together to support Alison?
- How were Alison's care and support needs assessed?
- Was the criminal justice route for Alison the appropriate way of managing her behaviour and what were the other options?
- Was Alison's mental capacity assessed particularly in relation to a presentation of self-neglect and hoarding?
- How was Alison's mental health assessed and how was she supported particularly when her support plan ended? Were there other conditions, including her use of alcohol, that affected Alison and were these considered?
- Were offences and incidents against Alison appropriately dealt with and was she supported?
- What support was in place when Alison was released from prison and how was information shared?

- To identify and highlight for learning purposes any areas which are considered to be good practice.
-

3. Chronology

3.1 Since June 2014, Alison had at various times been the subject of a police Risk Management Plan (RMP). These plans had been put in place to help manage a number of regular and continuing complaints from neighbours. These complaints had included threatening the neighbours and causing disturbances in the street. In the main these incidents were attended by the police. There is good evidence that the police spent a lot of time trying to assist, support and reassure Alison.

3.2 This pattern of behaviour continued into January 2015. At the end of January 2015, after dealing with two recent neighbour complaints and concerns over Alison the police Harm Assessment Unit (HAU) referred Alison to Adult Social Care (ASC) Access Service but were informed that as the primary need appeared to relate to her mental health the concerns would be sent to her GP.

3.3 There was one further neighbour report in February 2015 and then in July 2015 both police and the Community Psychiatric Nurse (CPN) team received several calls from Alison of an incoherent nature. Police attended the address and found Alison well but intoxicated. Alison told officers that she just needed someone to talk to. There were similar neighbour complaints and calls raising concerns for Alison's welfare in November and December 2015.

3.4 During April 2016, it is apparent that the community mental health team were involved with Alison. Alison contacted the team and stated that she no longer wished to engage with the service. Police and the mental health team received calls that were not rational and gave cause for concern that Alison's mental health was deteriorating. After a number of contacts, it was established that Alison had not been taking her medication and when this was resumed her behaviour was seen to stabilise.

3.5 During the remainder of April 2016, the mental health team visited Alison twice daily to supervise and ensure that Alison was compliant with her medication regime. Police received a call from a neighbour and on visiting it was noted that Alison had no electricity. This was to become an ongoing concern and one that was not resolved.

3.6 During July and August 2016, there was continued contact between Alison and the mental health team. There was a further neighbour complaint from a person, who was themselves vulnerable who complained that Alison had been a problem for the last 3 years. The Advocacy Service became involved with Alison and at Alison's request they made enquiries to establish if Alison was being managed under any form of mental health order.

3.7 During the remainder 2016 and into 2017, Alison was in contact with both the CPN and Advocacy Service. Alison was recorded as being compliant with her medication. A medical review recorded that Alison had good insight into her own mental health and when reviewed there were no current concerns regarding abusing alcohol.

3.8 Alison's behaviour was stable until an incoherent call was made to police in March 2017. It was recorded that the police used to have regular contact, but this had been withdrawn on the advice of the mental health team as they felt the police attention 'fed' Alison's mental health issues.

3.9 There was some evidence that Alison's address had been subject to some graffiti and other damage in the form of a broken window by a stone being thrown. This damage was caused by person unknown.

3.10 During May, June and July 2017, there were incidents reported by agencies of Alison's deteriorating mental health. Alison missed some appointments and was calling agencies expressing concerns regarding her pet rabbit. This culminated in an incident at the end of July where neighbours reported that Alison was holding the rabbit out of a window. Police attended and the rabbit was removed and had to be put down due to its poor condition. The police noted that there were concerns regarding Alison's deteriorating mental health, that she was not taking her medication and that she was not able to care for herself. As there was a belief that relevant agencies were engaged with Alison no referral was made for a care assessment. In some of the interactions with Alison it was apparent that she was intoxicated.

3.11 At the beginning of August 2017, the police reinitiated the RMP. Alison remained under the care of the community mental health team, but her engagement fluctuated, and she was on occasions aggressive with staff. As a risk management measure the mental health team initiated that any visits should be by two staff. The mental health team recorded in mid-August 2017 that Alison's changes in presentation were not due to her use of alcohol.

3.12 There was a multi-disciplinary team meeting (MDT) to discuss Alison being discharged from the mental health service. This meeting considered the Care Plan Approach (CPA) and the section 117[1] aftercare. Records have been checked for this review and it has been established that Alison would not have met the criteria for 117 aftercare.

3.13 In mid- September 2017, there was a further report of Alison shouting at neighbours. Police attended but were not able to contact Alison for several days. The police noted that the condition of the property was poor and presented a potential fire risk. A referral was made to the fire service. The fire service followed this up, but Alison declined the service. There was no referral made by police to the Harm Assessment Unit (HAU) at this time. Within a few days a CPN and Doctor from the mental health team attended the address and saw Alison. They made no mention of the condition of the property and recorded that Alison was welcoming and appeared mentally stable.

3.14 In the middle of October 2017, Alison made a series of calls to police, fire, ambulance and the mental health service threatening to 'blow the town up' and set fire to

[1] Section 117 Mental Health Act 1983 - the duty on clinical commissioning groups and local authorities to provide or arrange for the provision of after-care services for people who, having been detained under certain provisions of the MHA 1983, are discharged into the community.

her property. The agencies liaised well and attended the address where Alison was seen and now calm but believed she was intoxicated.

3.15 In mid-November 2017, there was another report of Alison shouting, threatening and assaulting a neighbour. Alison was arrested and charged with an offence. She later appeared at Court and received a restraining order (14th April 2018). The police again identified a fire risk at Alison's address and made a referral to the fire service.

3.16 In November 2017, there was a further report of damage at Alison's property, although it would appear that the damage was old. It is not clear how the damage was caused.

3.17 In March 2018, the community mental health service visited Alison at the address and noted that the property was in a poor condition. Alison was living upstairs. There was no toilet or shower facilities due to frozen pipes. Alison was informed of a planned MDT to discuss the support from the community mental service being withdrawn. At this time the mental health service also recorded that Alison's risk of suicide, neglect and violence or aggression were all deemed as low risk. There followed another report from neighbours of Alison being threatening and racially abusive. The police implemented a further RMP. Despite this there was an MDT attended by police and the mental health service and it was agreed by all that Alison would be discharged by the mental health service. The police recorded from this meeting that a referral was made to ASC triage team and that the GP was informed of the discharge from the mental health service. There is no record of ASC receiving this referral from the police.

3.18 In mid-April 2018 the GP attended Alison's address with an environmental worker, Alison would not allow them access to the address. A week later Police, ambulance and fire services attended Alison's address on the report of a fire at the address. It was found that Alison had left the address, removing items of clothing with two suitcases. When spoken to Alison stated that the fire had started from a discarded cigarette, the suitcases were found to contain random items. Alison was detained under the provisions of section 136 of the Mental Health Act[2] and taken to a place of safety. Alison was later discharged having been assessed and discharged to the care of her GP and returned to her home address. The fire service had deemed it was safe for her to do so, in terms of property safety. There is no evidence that there was any consideration of Alison re-engaging with mental health services, a plan being put in place or being assessed under the Care Act. Alison was subsequently arrested and interviewed in relation to the fire, but no further action was taken.

[2] Section 136 Mental Health Act 1983 - If a person appears to police to be suffering from mental disorder and to be in immediate need of care or control, the police may, if they think it necessary to do so in the interests of that person or for the protection of other person remove the person to a place of safety.

3.19 The fire service made a referral to ASC and it was agreed that a screening visit would be made by the triage team with a view to allocation. Two days after the fire Alison was assessed by the mental health service.

3.20 At the beginning of May 2018, police were again involved with Alison after she made a number of calls, initially stating that she had been robbed. She went on to make allegations about members of her family, it was established these were unfounded. This information was passed to the social worker undertaking the screening visit.

3.21 In mid-May there was an initial assessment by a social worker from the Triage Team. Alison did not allow the social worker into the property, but Alison's current living conditions were explored and what support she had available to her. The case was closed as there were no identified care and support needs at this time.

3.22 In August 2018, there was another incident where Alison assaulted a neighbour and used offensive and racially offensive language. The police dealt with all the matters appropriately. The neighbour did not support a prosecution as this was not their intention for making the report. The police also noted that Alison's living conditions were very poor. This was also being reported by neighbours with sightings of rats amongst accumulating rubbish.

3.23 At the end of September 2018, following contact from the district council, regarding Alison's mental health deteriorating Alison was visited by a social worker. Alison declined support and it was recorded that Alison had mental capacity to make this decision. After this visit an ASC manager contacted the social worker and suggested that a multi-agency meeting was convened to establish a support plan for Alison. There is no evidence that the suggested meeting was convened. In November 2018, a neighbour of Alison's contacted - the ASC Access Team and expressed a concern that Alison was neglecting herself. At the beginning of December 2018, the social worker visited Alison, the social worker was not allowed in the property but recorded that Alison had stated that she was managing well. The social worker and GP concluded that Alison was coping well and did not appear to require mental health support.

3.24 Through April and May 2019, there was further evidence that Alison was failing to cope and her situation was deteriorating. A representative from the electricity provider reported concerns to ASC regarding the state of Alison's property. The police also responded to two further reports from neighbours of Alison being aggressive and threatening. At the end of May 2019, Alison was visited by a social worker. Alison declined any support. The social worker did not gain access to the property. There was no contact or liaison with other services. The case with ASC was again closed.

3.25 In June 2019, a neighbour reported the state of Alison's property to Regulatory Services. Staff from the service made enquiries with most agencies that had been involved with Alison. At around the same time a neighbour also reported to police that Alison had spat at their child.

3.26 ASC recorded that they received contact from Regulatory Services but responded that the case was 'predominantly a housing issue'. At the end of June 2019, ASC again opened a case in relation to the concerns being raised about Alison. Within days the case was again closed on the basis that Alison had been seen regularly and was engaging with adult social care. Alison was given assistance on some financial issues but there is little evidence that her situation was considered holistically, or that she received any advice on self-neglect.

3.27 At the beginning of September 2019, Alison breached her restraining order by confronting her neighbour. Alison was charged with an offence of harassment and was later fined at court. There is no evidence that any other referrals were made to other agencies. In December 2019, neighbours continued to raise concerns about Alison's living conditions, that she had no utilities at the address and was still placing excrement outside of the address.

3.28 During December 2019 and January 2020, the social care worker-maintained contact with Alison to assist with managing her debts to the utility companies. At the end of January 2019, police were notified of two further instances of harassment towards neighbours. No further action was taken as the complainants could not be seen for statements. There were also no police referrals to their HAU for consideration of referral to other agencies.

3.29 In March 2020, the social care worker discussed concerns with the GP regarding Alison's mental health and her poor living conditions. There continued to be reports from neighbours, including a report of a homophobic hate crime.

3.30 The social care worker recorded that Alison had no social care needs and that she was independent with her aspects of daily living. This was not consistent with other information being received. Due to ongoing incidents the police re-referred Alison to ASC. It was apparent that not only was Alison causing distress to her neighbours but was the subject of anti-social behaviour herself. Complaints were also received by Regulatory Services regarding the poor environment around Alison's property, this again included the fact that human faeces was outside her address. The neighbour highlighted that they had previously privately funded a skip to work with Alison to clear the outside of the address.

3.31 At the beginning of July 2020, a neighbour made a complaint against Alison stating that she breached the restraining order that was in place. Alison was summonsed for this offence, but there were further offences recorded in mid- July and August. At the same time police made referrals to the mental health crisis team as did the District Council. The same issues were highlighted, deteriorating mental health, living in conditions that were unsanitary and a risk to her and others. The GP was informed and visited Alison and persuaded her to undertake an assessment with the mental health team.

3.32 This assessment took place in mid-August 2020, the diagnosis was a non-organic psychotic disorder, Alison was compliant with her medication and had no suicidal ideation. It was noted that there were some features of autistic spectrum, but there was no follow up

on this. It was deemed that there was no role for secondary mental health and Alison was referred back to her GP.

3.33 During December 2020, there were a series of incidents with neighbours which constituted offences of assault (racially aggravated) and public order offences. Initially neighbours asked only for the incidents to be recorded but due the persistent nature ultimately required police action. In January 2021, Alison received a community order for a previous breach of the restraining order and started to engage with the National Probation Service (NPS). The NPS recognised that Alison's living conditions were poor and with consent engaged with ASC.

3.34 In February 2021, there was a further report public order offence by Alison with her neighbours. In April 2021, following a further incident Alison was arrested and charged with four separate offences. In May 2021, at Crown Court Alison received a four-month prison sentence.

3.35 In June 2021, Alison was being considered for early release under a Home Detention Curfew (HDC) but her property was deemed unsuitable as it had no electricity. In July 2021, Alison was released to an address in Birmingham. Prior to Alison's release there was contact between the NPS, and local police involved in Alison's case.

3.36 Through July and into August 2021, there was contact between the NPS and Alison, this was in the form of phone calls and one visit to the office. The discussions were to establish Alison's initial sentence plan and regarding the issues of getting electricity to her home. Alison informed the service that she intended to return to her address at the end of her HDC and the suitability of the address was discussed.

3.37 In the following four weeks Alison failed to be available for call or attend appointments on 6 occasions. Warning letters were issued. The NPS reported Alison to police as a missing person. Police made a check at Alison's home address and she was discovered deceased at the address.

4. Analysis of involvement

4.1 How well did organisations work together to support Alison?

4.1.1 During periods of this case there is evidence that Alison was being intensively supported. In 2016, the mental health team was undertaking twice daily visits to support Alison with her medication and ensure her stability. Over the course of the period focused on in this review the police had four RMPs in place. These plans are usually made in relation to anti-social behaviour but are also used to address ongoing recognised vulnerability. The plan involves a heightened and more regular attendance from police, often the neighbourhood policing teams. This means that officers become well acquainted with the problem and the person involved. There is also evidence that the GP undertook joint visits with environmental health, which was good practice.

4.1.2 The application of RMPs in this case is seen as good practice and their use has been similarly recognised in other reviews. The continued practice of RMPs would be greatly enhanced if they were used as the foundation of or as part of a multi-agency plan. The below was identified learning from the case of David, a Worcestershire Safeguarding Adult Review in 2018.

> '*Where an agency puts a plan in place, as in this case the police with the RMP, all agencies should seek to support this plan to achieve the most coordinated and far-reaching support for the service user.'*

4.1.3 During the course of the case there were numerous agencies working to support Alison including the mental health service, police, adult social care, the fire service, Council regulatory services, housing, advocacy, the Probation Service and the RSPCA. Many of these agencies were involved at the same time or as a result of a referral from one to the other. Despite this there is little evidence of any joined up working to really understand what the key issues were for Alison and how they could be addressed.

4.1.4 Apart from the opportunity that the RMP presented there were other opportunities to draw together a multi-agency coordinated response. There were concerns that Alison was neglecting herself and there was real evidence of her living in unsuitable conditions, with no access to utilities for extended periods of time. The Worcestershire self-neglect policy[3] gives clear direction on drawing together a multi-agency plan and the steps to escalate the case to a s42 enquiry if the plan does not have the desired outcomes. The Worcestershire Safeguarding Adults Board (WSAB) also has in place a document of the role of lead professional[4] which should be put in place in complex cases. Both of these documents have been in place since a WSAB SAR in the case of RN from 2017[5]. The areas of coordinating complex cases and the multi-agency response to them is not new and the tools to address some of the issues are available.

> The Worcestershire self-neglect policy has been reviewed and has just been re-launched due to concern re the number of SARs focusing on self-neglect The issue for the WSAB and its partners is why this guidance and the previous learning is not being utilised by practitioners.

4.1.5 The reflective discussion for this review also highlighted that the partnership is seeking to develop and implement a procedure for use in complex cases (CARM – Complex Adult Risk Management). This guidance will be used where a person has mental capacity but

---

[3] Worcestershire Self Neglect Guidance 2017 - https://www.safeguardingworcestershire.org.uk/documents/guidance-for-professionals-working-with-people-who-self-neglect-what-can-you-do-and-when-should-you-get-additional-help/

[4] WSAB guidance on role of lead professional - https://www.safeguardingworcestershire.org.uk/wsab/policies-procedures-a/

[5] WSAB SAR case of RN - https://www.safeguardingworcestershire.org.uk/documents/sar-rn/

does not wish to or cannot engage with services and this presents a risk to themselves and/or others.

4.1.6 In developing this guidance and considering the guidance that is currently in place the partnership will want to consider what the barriers are to staff accessing and using it and how it can be effectively embedded.

4.1.7 In this case there was evidence that a- safeguarding manager from ASC recognised that the case needed to be discussed in the multi-agency arena and directed that a meeting should be convened (September 2018). This did not happen on the basis that Alison did not want support. This failed to recognise or take into account the ongoing risk to Alison and others or consideration for use of the self-neglect policy and using the suggested meeting as a basis for this. It also failed to consider the overarching responsibility of the wellbeing principle under the Care Act 2014 (discussed in more detail at section 4.2)

Recommendation 1

Worcestershire Safeguarding Adults Board should consider how aspects of learning from previous reviews on self-neglect, multi-agency approaches to complex cases and lead professionals, which are repeated in this case are embedded with professionals practice across partner agencies.

Recommendation 2

Worcestershire Adult Social Care should ensure that staff arrange a multi-disciplinary meeting in response to concerns about self-neglect as required by the WSAB Self-neglect and hoarding policy.

4.2 How were Alison's care and support needs assessed?

4.2.1 There were referrals made to ASC for consideration of an assessment of care and support needs. These generally followed concerns following reported incidents (January 2015, April 2016, July 2017, August 2017, September 2017, April 2018, May 2018, April 2019, May 2019, June 2019, July 2019, September 2019, January 2020, May 2020, June 2020, August 2020) These referrals were variously made by police, neighbours, RSPCA, Regulatory services, fire service and electrical provider.

4.2.2 None of these referrals led to an assessment under the Care Act 2014 on Alison's care and support needs. There are incidents where the police did not make referrals to their Harm Assessment Unit (HAU) where they should have done, and this would have resulted in further contacts with ASC. Some of these referrals were not made due to the perceived lack of response on previous occasions.

4.2.3 The referrals received by ASC were opened and then closed on the basis that Alison did not have eligible needs (May 2018). Alison was spoken to and claimed that she could cope and was coping well, this was accepted without the necessary further enquiry and available evidence to the contrary. (September 2018 and December 2018). On occasions the

issues were not viewed holistically and viewed as a single agency issue ('housing issue' June 2019).

4.2.4 Many of these contacts failed to consider the considerable history and obvious evidence that despite Alison's own assertions she was not coping well and did need support. Alison was without basic services of heat, light and water for extended periods (2016), her address was in a poor condition was deteriorating further. There was a risk from hoarding and at least one fire which caused significant damage.

4.2.5 There should, as already stated, have been consideration of self-neglect and hoarding policies but there was a lack of consideration of the wellbeing principle, as introduced by the Care Act 2014, which applies in all cases where the local authority undertakes a care function or making a decision in relation to a person. This therefore should have featured in the decision making when considering Alison's eligibility for care and support. The definition of wellbeing is a broad concept, but it does include mental health and emotional wellbeing, social and economic wellbeing and suitability of living accommodation. Where the concerns were raised and referrals made, they presented opportunities to explore Alison's circumstances and consider whether it would be possible to provide information, or support that prevented abuse or neglect from occurring.

> '*Promoting wellbeing means actively seeking improvements, at every stage in relation to the adult with care and support needs (regardless of whether they have eligible needs or not)*[6]

4.2.6 Where Alison declined an assessment and claimed that she was coping well despite available evidence and presentation consideration could have been given to undertaking an assessment under section 11 of the Care Act[7]. This provision allows for an assessment to be undertaken without the person agreeing to it in certain circumstances, including the adult is experiencing, or is at risk of, abuse or neglect. This would have been apparent in Alison's circumstances.

When evaluating the adult's needs for care and support, if a needs assessment under section 9 of the Care Act 2014 has not already taken place, it will be necessary to evaluate whether a needs assessment should be offered, and in certain cases, undertaken despite

refusal where it may appear that the adult has needs for care and support, and is experiencing, or is at risk of abuse or neglect.[8]

[6] &9 Multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands (accessed 21/03/22) - https://www.safeguardingworcestershire.org.uk/documents/west_midlands_adult_safeguarding_policy_and_procedures/

[7] Care Act 2014. Section 11 (2)(b)

Recommendation 3

Worcestershire Adult Social Care should ensure that the wellbeing principle is being considered in all areas of delivering care functions and where an adult declines a care assessment that consideration is given to section 11, Care Act 2014.

4.3 Was Alison's mental capacity assessed particularly in relation to a presentation of self-neglect and hoarding?

4.3.1 The presumption in the Mental Capacity Act (MCA) 2005 is that adults have the mental capacity to make informed choices about their own safety and how they live their lives. At various stages in this case Alison is recorded as having capacity to understand, weigh up and retain information to allow her to make informed decisions. There is no evidence that Alison lacked mental capacity, but she did continue to make what might be considered as poor decisions that impacted negatively on her and those around her.

4.3.2 Capacity is not only the ability to make a decision at the time needed, but also the ability to carry this out. Decisional capacity relates to the person's ability to understand, retain and weigh up information and then to communicate their decision. Executive capacity relates to a person's ability to put a decision into action.[9] There was a lack of consideration of Alison's ability to turn the decisions that she made into actions. Whilst Executive Capacity is not a legal term it does allow professionals to consider and identify where persons are unable to turn their decisions into actions and therefore how they might be supported.

4.3.3 The MCA Code of Practice states: -

> *There may be cause for concern if somebody:*
>
> *• repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or*
>
> *•makes a particular unwise decision that is obviously irrational or out of character.*
>
> *These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation, taking into account the person's past decisions and choices.*[10]

Whilst agencies maintained that Alison had capacity her lack of executive capacity and the repeating pattern of making unwise decisions which was putting her at risk warranted

[9] Worcestershire safeguarding adults board multi agency self-neglect guidance 2017
[10] Mental Capacity Code of Practice, 2007

further consideration and this would have taken professionals utilising the self-neglect policy or considering another multi agency approach.

4.3.4 In a guide to professionals in making and recording Mental Capacity assessments issues by 39, Essex Chambers it is recognised that staff need to be able to justify not undertaking a mental capacity assessment. `*Whilst the presumption of capacity is a foundational principle, you should not hide behind it to avoid responsibility for a vulnerable individual. In our experience, this can happen most often in the context of self-neglect where it is unclear whether or not the person has capacity to make decisions*.'[11]

Recommendation 4

Worcestershire Safeguarding Adults Board should seek assurance that professionals understand the concept of Executive Capacity, especially in the context of self-neglect and hoarding and how they may be supported.

4.4 How was Alison's mental health assessed and how was she supported particularly when her support plan ended? Were there other conditions, including her use of alcohol, that effected Alison and were these considered?

4.4.1 Alison received some intensive community support, in early 2016 Alison was receiving twice daily calls to support her with her medication regime. There is recording to the effect that on occasions Alison was abusive and it was apparent that she was intoxicated. There is also contradictory information as to whether alcohol was a feature of her erratic behaviour.

4.4.2 Police offers who attended many of the incidents that were reported by neighbours, often reporting that Alison was intoxicated stated that when they met her a short time later she did not appear under the influence of alcohol.

4.4.3 During the latter part of 2018, the mental health services were discussing discharging Alison from the service. It was Alison's wish for the support to end. She is recorded as stating that she was complying with her medication, and it was now just a matter between her, her neighbours and the police.

4.4.4 In March 2018, Alison was assessed by the Community Psychiatric Nurse (CPN) for risk of suicide, neglect and violence aggression and was deemed low risk on each. This is surprising as in November 2017 Alison was arrested for assault on a neighbour and a breach of a restraining order, she was only sentenced for this offence in April 2018. One week following this assessment the police re-instigated a RMP after Alison was reported by neighbours for being abusive, including using racial abuse. Poor living conditions, including potential hoarding activity had also been noted.

4.4.5 In mid-March there was a professionals meeting which was attended by police and the mental health team. It was agreed that Alison's behaviour was possibly as a result of the

[11] 39 Essex Chambers, Carrying out and recording Capacity Assessments, June 2020

use of alcohol and there was an agreement to discharge from the mental health team. There was no evidence of substance misuse services being considered. The following week there was a fire at Alison's address, and she was detained by police under s136[12] Mental Health Act. Alison was assessed and deemed fit to return to her property.

4.4.6 Over the following months there were more reports from neighbours of Alison's mental health deteriorating. This was mirrored by a deteriorating condition of her property with reports of rats and waste, including human waste being present. The police attended and dealt with numerous calls regarding public order and assault offences. The GP requested a mental health assessment. A community psychiatrist and a CPN, who had previously worked with Alison attended her address. The assessment was conducted at Alison's address. It is recorded that Alison had previously been diagnosed with a non-organic psychotic disorder, with autistic traits. Alison was compliant with medicines, and it was deemed there was no role for secondary mental health, so she was discharged to the care of her GP.

4.4.7 It would have to be viewed as overly optimistic, on the evidence available, to discharge Alison from the support of mental health services without any other support plan being in place and expect that she would be able to cope. Her behaviour was attributed to her use of alcohol, but it is apparent from information received from the police that often when reports of chaotic behaviour were received there was no evidence of Alison being intoxicated.

4.4.8 There is now a system in place which has removed barriers between GP services and secondary mental health care. This allows GPs to bring cases for discussion with mental health services to establish what support may be available.

4.4.9 There was a recognition that Alison demonstrated Autistic traits, but this was not diagnosed. It may have assisted Alison to have been assessed to see if there was any support that could been offered for this.

4.4.10 It was apparent in discussion for this case that most agencies, including mental health services had a lack of social history for Alison. There were areas involving her past and family that were not readily known or available to practitioners and therefore not referred to in assessments. The clearest social history was available from Probation Services.

Recommendation 5

Herefordshire and Worcestershire Health and Care NHS Trust when discharging persons from mental health support should consider with partners what support will be available to the person and how the progress of the discharge will be reviewed.

Recommendation 6

[12] S136, Mental Health Act 1983 – Detention of a mentally disordered person from a public place to a place of safety.

Herefordshire and Worcestershire Health and Care NHS Trust should where there is a consideration that a person may have features of Autism consider arranging an appropriate assessment.

4.5 Were offences and incidents against Alison appropriately dealt with and was she supported?

Was the criminal justice route for Alison the appropriate way of managing her behaviour and what were the other options?

4.5.1 Police attended many incidents both with Alison as a victim and Alison as an offender. It is clear that the police had a good understanding of Alison's issues and their good use of RMP's has been acknowledged. On the whole suitable referrals were made to other agencies but not on all occasions. Some of this may have been due to over familiarisation with the situation and a perceived lack of response from agencies previously referred to.

4.5.2 A key area which addresses many of the key lines of enquiry was professionals getting together to pool resources, knowledge, and powers. By doing this there would have been the ability to innovate to support Alison and her neighbours. During the case discussion with staff from the District Council private sector housing team identified that they could have taken out warrants to repair services (water and electricity) at the address. This would not have been intended punitively but using enforcement powers as part of an overall support package. Whilst enforcement should be used as a last resort, it has the potential to act as leverage for the person to accept the necessary support.[13]

4.5.3 It is clear from the reports made by neighbours that their desire was not to have Alison prosecuted but for her behaviour to stop. There was evidence of neighbours making reports of criminal behaviour but not wishing to support a criminal prosecution and an example of a neighbour privately funding a skip to assist Alison with the removal of rubbish from outside her address.

4.5.4 There were attempts to use community resolutions to moderate Alison's behaviour, but the reality of the situation was that without a plan put in place by all agencies involved there was always a likelihood of a criminal justice outcome for Alison. Whilst this was not the best outcome as any sentence was likely to be short and therefore no mental health intervention would be available to Alison whilst in custody.

Recommendation 7

In complex cases multi agency discussions should include what powers partner agencies have access to which could be used to ensure that the necessary level of support is available, this should include the appropriate use of enforcement powers as identified in the Self Neglect and Hoarding Policy.

[13] Worcestershire Safeguarding Adults' Board Multi Agency Self Neglect and Hoarding Policy, May 2022

4.6 What support was in place when Alison was released from prison and how was information shared?

4.6.1 Prior to Alison's release from prison the National Probation Service (NPS) appropriately considered the suitability of the address that Alison was to be released to. NPS engaged in discussion with Police to understand what the impact to neighbours would be if Alison returned to her home address. Alison was released on a Home Detention Curfew (HDC) and the equipment to monitor this required an electricity supply. For these reasons Alison's address was deemed unsuitable for release and Alison was allocated support accommodation in another area. Alison was released from prison in July 2021, with her HDC expiring 4 weeks later.

4.6.2 Alison initially engaged well with the accommodation support staff and her NPS offender manager. She maintained good contact and there is evidence of Alison being well supported. Alison did make it clear that at the conclusion of her HDC she intended to return to her address, which was still devoid of utility services. The support staff did make enquiries that Alison had plans to reconnect the property services and she stated she was being supported by her mother to assist this.

4.6.3 When Alison returned to her address the NPS did not make any contact with the Police or Adult Care Services to inform them. Alison was vulnerable and whilst she did state that her mother was to support her a safeguarding referral would have notified local agencies that she was returning to the area and afforded the opportunity to offer assessment. A notification to Police would also have allowed for risk assessment regarding Alison returning to the locality of her previous offending and what the impact of would be for her in terms of re-offending and to her neighbours who had been the victims of her offending.

4.6.4 Within a short period of time on returning to her address Alison failed to make the necessary contact with NPS. Alison's means of contact would have been limited, she had been offered a mobile phone but had declined. Alison failed to make three contacts and in line with NPS guidance three warning letters were issued. It was not until 5 weeks after Alison had returned to her address that NPS raised a concern with Police to report Alison as a missing person. As result Police attended Alison's address and after forcing entry found her deceased.

Recommendation 8

The National Probation Service, when dealing with a person who is considered vulnerable should notify relevant agencies when the person is moving to an area, particularly if that is a locality relevant to their previous offending.

Recommendation 9

The National Probation Service when dealing with a person who is vulnerable, and they fail to make contact should when considering the compliance issues should also consider whether notifications need to be made to other relevant agencies according to the presenting risk.

5. Conclusions

5.1 Alison was person who had a significant history with mental health services and had been afforded relatively intensive support within the community from these services. Alison wished for this support to end, and this happened after discussion with Police, who also had significant involvement with Alison. It is not clear that consideration was given to how Alison would be supported going forward.

5.2 A large number of services were involved with Alison at various stages, Mental health, GP, Police, ASC, Housing, Regulatory Services (environment), Fire Service, RSPCA, National Probation Service and Ambulance. There was clear evidence that Alison was neglecting herself, yet consideration was not given to the use of the existing self-neglect guidance. What this case required at an early stage was for agencies to work together in a coordinated way, to formulate a plan with Alison at the centre of it and for each agency to identify how they could contribute to support her. The Police expended considerable resource and energy on a number of Risk Management Plans and whilst this was commendable and the staff involved knew Alison well, the case cried out for a coordinated multi agency approach.

5.3 Concerns were raised with ASC on a number of occasions, but these were not progressed on the basis that Alison did not wish to engage. There was a lack of exploration of Alison's situation and ensuring that she had the information she needed to take control of her care and support and choose options that were right for her.

5.4 As this case progressed it was clear that the likely outcome was that Alison would be arrested and dealt with through the courts. The only way this could possibly have been avoided was by the coordinated multi agency approach already discussed. The Government Female Offender Strategy[14] recognises that short terms of imprisonment for women with mental health and substance misuse issues are not effective. The NPS worked well with Alison on her release from prison and of all agencies appeared to have the greater understanding of her history. Alison returned to her home address once her Home Detention Curfew had finished and when she did other agencies should have been informed.

[14] Female Offender Strategy,2017 HMG Ministry of Justice - Female Offender Strategy - GOV.UK (www.gov.uk)

6. Recommendations

Recommendation 1

Worcestershire Safeguarding Adults Board should consider how aspects of learning from previous reviews on self-neglect, multi-agency approaches to complex cases and lead professionals, which are repeated in this case are embedded with professionals practice across partner agencies.

Recommendation 2

Worcestershire Adult Social Care should ensure that staff arrange a multi-disciplinary meeting in response to concerns about self-neglect as required by the WSAB Self-neglect and hoarding policy.

Recommendation 3

Worcestershire Adult Social Care should ensure that the wellbeing principle is being considered in all areas of delivering care functions and where an adult declines a care assessment that consideration is given to section 11, Care Act 2014.

Recommendation 4

Worcestershire Safeguarding Adults Board should seek assurance that professionals understand the concept of Executive Capacity, especially in the context of self-neglect and hoarding and how they may be supported.

Recommendation 5

Herefordshire and Worcestershire Health and Care NHS Trust when discharging persons from mental health support should consider with partners what support will be available to the person and how the progress of the discharge will be reviewed

Recommendation 6

Herefordshire and Worcestershire Health and Care NHS Trust should where there is a consideration that a person may have features of Autism consider arranging an appropriate assessment.

Recommendation 7

In complex cases multi agency discussions should include what powers partner agencies have access to which could be used to ensure that the necessary level of support is available, this should include the appropriate use of enforcement powers as identified in the Self Neglect and Hoarding Policy.

Recommendation 8

The National Probation Service, when dealing with a person who is considered vulnerable should notify relevant agencies when the person is moving between areas, particularly if that is a locality relevant to their previous offending.

Recommendation 9

The National Probation Service when dealing with a person who is vulnerable, and they fail to make contact should when considering the compliance issues should also consider whether notifications need to be made to other relevant agencies according to the presenting risk.