James

A Safeguarding Adults Review using Rapid methodology (SARR)

Overview Report

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1. Introduction

1.1. James was a 34-year-old white British male who died at home from alcoholic ketoacidosis[1]. He was discovered by his sibling who had not had a response to their telephone calls. James had several long-term conditions that affected his life with communication being a particular issue. He had dyslexia, Attention Deficit Hyperactivity Disorder, Borderline Learning Disability and was deaf, wearing a single hearing aid. James also suffered with type two diabetes as well as anxiety. James was alcohol dependent and used cannabis. It is not clear from agency records how long James had been a dependent drinker.

1.2. Following James' death, a LeDeR Focussed Review (Learning from Life and Death Reviews of people with a learning disability and autistic people) was undertaken. This SAR is mindful of the learning from that review and but will identify learning from a multi-agency working perspective.

2. Process and scope and Reviewer for the SAR

2.1. The Terms of Reference, including decision making, scope and methodology for the SARR can be found in Appendix 1. The review set out to cover an 11-month period prior to the death of James, being the time that risk was escalating. TSAB commissioned an independent reviewer to chair and author this SAR[2].

3. Family involvement in the Review

3.1. A key part of undertaking a SAR is to ensure that families are integral to the review process. Families can provide their views and insights that professionals may not have. A more complete picture of the person is often available from families who often provide a unique perspective. TSAB wrote to James' mother and sibling and informal carer to inform them of the review. Family and carer were supported by a key worker in an advocacy role. The author met with James' family members and then the carer separately alongside their key worker; their views and thoughts are included throughout this report where they are relevant to learning. Both family members and the carer believed that the timeframe for the review was right as they thought that James' deterioration did indeed start at about 11 months preceding his death. Family and carer were clear that they wanted professionals to learn from the death of James, James' sibling stated that they believed that if support had been in place sooner, he may not have declined so much in those 11 months.

3.2. Family members were kept informed of the progress of the review and the author met with them to with their advocate to feedback on the findings, learning and recommendations. They were

[1] **Alcoholic ketoacidosis** is the build-up of ketones in the blood due to alcohol use. Ketones are a type of acid that form when the body

[2] Karen Rees is an Independent Safeguarding Consultant with a nursing background. Karen worked in safeguarding roles in the NHS for a number of years. Karen is completely independent of TSAB and its partner agencies.

informed of the next steps for sign off and publication. The offered thanks for the work that has been undertaken and felt that it may make a difference in future.

4. James: background and key events leading up to the death of James

4.1. This initial section will provide key information known to agencies and key issues and events that occurred. The later sections will provide analysis with thematic learning and recommendations. These were identified after the practitioners Learning Event where themes were discussed in depth to provide a window on the systems that people are supported by and within which professionals work.

4.2. James had been known to multiple agencies for his entire life from childhood into adulthood. Most significantly James had been subject to a considerable amount of trauma across his life. James became a looked after child when he was five years old spending the rest of his childhood in various foster homes and children's homes.

4.3. Most of the historical background regarding key issues that impacted on James came from the police and local authority reports for this SAR and was supplemented by information from the family.

4.4. James was born deaf, wore hearing aids from a young age and had learned to lip read well. James' sibling informed the author that James was a 'cheeky chappy' and that the two of them were 'thick as thieves' growing up. The family went on to say that James was known by many people in the area where he lived but that he was also 'very gullible' and that this often led to problems for him but that he was always thinking and caring for others. This was also borne out by the carer who stated the same.

4.5. James became known to the person who was to become his carer through mutual friends who had previously 'taken James in'. The carer stated that this previous arrangement had failed when James was too disruptive to be managed but that these friends had set James up in a flat in a local area. James was unable to maintain this as his apparent difficulties in managing his life and finances led to him getting into arrears with the landlord and James was subsequently evicted. This flat had been in a local area away from where he spent the last few years of his life and when he became homeless, he moved to a shared housing facility offered by the homeless team in that area. It appears that James was then not fitting in to the household with other tenants not liking James' loud music late at night (James never slept well and his deafness meant that he played his music loud). James was also exploited by those in the tenancy where money was sought from him for joint shopping, but that the food they bought was not food that James ate.

4.6. Following that, the carer stated that he then became guarantor for a flat local to where they and James' sibling lived. It was after this time that the carer gradually took on more and more support for James and became an informal carer.

4.7. Both family and carer also mentioned James' fiancée and stated that their relationship was a turbulent one and that had been on and off for years. James' carer stated that the couple would often be drinking together and that it was when they were drunk that they had arguments. The

carer stated that the couple had only recently got engaged and that they had supported the couple to have a night away to celebrate their engagement. James' sibling explained that their recent engagement was evidence that James did see a future for himself and that he did not want to die.

4.8. James came to the attention of the police as a victim of rape when he was 12 years old. Later James was known to be offering sexual favours for cash and was being sexually exploited by an adult male. This sexualised behaviour then continued into his adult life with concerns regarding him sex working. During the time frame of the review James came to the attention of the police on three occasions, the most significant was related to a sexual assault against him, for which a safeguarding referral was made. The other two occasions were one as a victim of phone theft and the other as an alleged perpetrator, offering drugs to a group of children. In the latter, James was named but not found in the vicinity of the alleged incident, so no action was taken. James had told the police that although he had been highlighted as a suicide risk, he stated that this was only when he was drunk.

4.9. James was initially supported by Adult Social Care services from just two years and five months before he died. This initial referral contained concerns in relation to James' vulnerability with regards to his previous history of abuse; current use of alcohol and substances, diagnosis of anxiety and depression and history of suicidal ideation/attempts. James was referred to an intensive support team, who provided him with support from a key worker for 16 months until just prior to the timeframe for this review. During this time a wellbeing assessment was undertaken, and a wellbeing plan was produced; this included plans to refer James for support in relation to his drug and alcohol use, his past trauma, and his ongoing mental health needs.

4.10. Safeguarding referrals were made as above and also in relation to bullying and abusive behaviour regarding his home being targeted in cuckooing[3] type behaviour and a self-neglect referral. Both of these were in the same year as the TCA team were working with him.

4.11. Referrals were made by the local authority to the mental health trust in respect of James' mental health needs; James' Borderline Learning disability was not diagnosed until he was 33 years old, 20 months before he died. James' sibling told the author that his literacy skills were at a very basic level and that he did not understand complex words or sentences. James had previously been known to the Mental Health Trust following a referral for support related to previous criminal activity and was known to probation. This was again due mostly to crimes when intoxicated. James was not under any probation orders during the timeframe of the review.

4.12. James was again supported by the Mental Health Trust two months into the timeframe of the review following a referral from a social worker. A plan was formulated with the help of a psychologist to explore long term work regarding self-esteem, low mood, and motivation. Ultimately James was discharged from the service due to the team not being able to engage with him. A further referral was made by a social worker four months later. It took three months of several attempts to meet meaningfully with James where he agreed to support. Due to other physical health complications, and not being home for appointments or answering the phone, there was only just beginning to be some relationship building with James that was intended to lead to further assessment and offers of

[3] **Cuckooing** is a practice where people take over a person's home and use the property to facilitate exploitation. It takes the name from cuckoos who take over the nests of other birds.

support, but further work had not happened before James died.

4.13. James came to the attention of the ambulance service mostly due to intoxication and/or complications associated with dependent drinking. He was mostly conveyed to hospital on these occasions. Most of these occurrences resulted in hospital admissions; the Acute Hospital Trust provided details of those admissions to the review as well as James' diabetic, dietetic and endocrinology clinic appointments.

4.14. Six months before his death, James was admitted to hospital for severe electrolyte derangement leading to confusion and hallucinations. This was related to poor diet and alcohol use; James was also treated for a chest infection. Two months later he was again admitted to hospital after being found verbally unresponsive; James self-discharged on this occasion 15 days later. The next admission was two months later when he was admitted after vomiting blood and having blood in his stools, this was again due to complications of his alcohol use; he was discharged two days later following treatment.

4.15. The alcohol support service also tried to engage James in treatment and counselling options following referrals from several sources. James had three episodes of care historically and during the timeframe of the review. The first was for a nine-month period five months before the timeframe of the review where harm minimisation was discussed. Contact and engagement with James was difficult and, in the end, he was discharged for not engaging. The second episode was five months into the timeframe of the review but there was no successful contact with James, and he was closed to the service. The final episode was two months before James' death. It is of note that James had agreed to engage with the support of his sibling, with appointments taking place at his home, but due to cancelled appointments by James and the service (due to sickness) there was no active service support before James died.

5. Learning themes to be addressed

5.1. When the initial information was gathered for the review, it was felt that the possible learning themes that were emerging were similar to those that had been seen previously in other local SARs and case reviews. The themes were compared across several recent reviews and were made available to the reviewer. The progress of actions against the emerging themes were also reviewed. This SAR will therefore look at how far services have come in their learning and also address any challenges to embedding learning. The SAR will also identify any new themes or new learning from repeat themes in order to progress learning further.

Professional response to Trauma; James' response to agencies

5.2. There appear to have been mixed responses to trauma[4] from the professionals involved. It does seem that most professionals did understand that James had been exposed to multiple traumas as a

[4] **Trauma** results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life

https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice#:~:text=Trauma%2Dinformed%20practice%20is%20an,biological%2C%20psychological%20and%20social%20development

child and that these continued into his adult life. It can therefore be suggested that the impact of the childhood trauma was apparent but also that trauma experienced by James continued. There were several responses by agencies to questions regarding adapting care to a trauma informed response.

5.3. It is known that in response to the harms and traumas experienced in a person's past and the ongoing traumas for James, professionals need to offer Trauma Informed Care (TIC)[5]. The main purpose of TIC is to increase professionals' awareness of how trauma can negatively impact on a person so that practices that might be inadvertently adding to trauma can be avoided. In using TIC, the sensitivity of professionals enables the person to see them as trustworthy and feel safe to disclose abusive experiences. Additionally, practices which give a person back choice, and some controls are viewed to be particularly valuable.

5.4. James was clear in his voice when he stated that he got fed up with telling his story over and over again and indicated that it retraumatised him. James appeared to therefore have insight into the impact of his trauma, but professionals did not appear to have been able to prevent him from telling his story repeatedly. This may well link in to how he engaged with services. It is of note that James did engage with some services and those tended to be the ones where he was unlikely to have to address his trauma issues e.g. he engaged with the dietician, and the diabetes clinic as well as attending GP for blood tests and for physical health complaints. James appeared to struggle more to engage with mental health, addiction, and social care services where there was likely to be more delving into his life story. This is a complex issue as, in order to understand a person, we need to understand their story but, where this leads to constant revisiting and therefore retraumatising, that is not in line with trauma informed practice.

5.5. Police have identified that on occasion it would have been better to have used out of court responses to some of the criminal activity that James was involved in (mostly when intoxicated) in recognition of a more trauma informed response.

5.6. It was also known by all professionals that James was hearing impaired and used a hearing aid. James did have two hearing aids but due to infection issues in one ear, he only ever used one. There was good evidence that there was knowledge by professionals of the need to communicate in a way that enabled James to understand what was being said. He was known to be good at lip reading. This did mean that there may have been issues with communication with James on the phone; it was not clear in records what James' literacy levels were given his borderline learning disability but as above the author has identified from family that this was limited. It is not clear how much his communication needs impacted on his engagement ability and motivation, but family and carer would say that this was significant.

5.7. It is important that where services are aware of a person having any form of literacy and/or communication issues, that systems are flagged and if the person would benefit from easy read literature/appointments then these should be provided. In this case it is clear that the carer offered a reading support but that would only be where James asked for help. It was not always clear how much of his non engagement was due to lack of understanding how and why he could access services for support.

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[5] Asmussen, Dr K. et al. (2020) **Adverse childhood experiences What we know, what we don't know, and what should happen next**. Early Intervention Foundation February 2020.
https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

5.8. Several previous SARs have identified trauma informed approaches and difficulties with engagement as being areas for learning. This is the first time though that a person has communicated what their difficulties are and may give new insight to systems learning. It is not known how much communication difficulties may impact on a person's ability and motivation to engage with services. In the case of James, there was not an ongoing feature of complete non-engagement but evidence that engagement was very sporadic and that his lack of motivation/ability to change was more of a feature. This links closely with trauma in the way that he did not engage meaningfully with addiction support services.

Previous Actions

- Trauma Informed Practice Event – November 2021 (Adult F) – resources on website and shared again as part of Domestic Abuse Awareness month – October 2022 (Molly)
- Safeguarding Explained: Trauma Informed Video – launched June 2022 (Adult F) – shared again National Safeguarding Adults Week (NSAW) 2022 (Molly)
- Trauma Informed Practice e-Learning added to suite of courses (Molly)
- Adverse Childhood Experiences (ACEs) E-Learning shared with Safeguarding Children Partnerships – November 2022 (Molly)
- Adult Sexual Exploitation and Adult Criminal Exploitation training commissioned and includes Molly as a case study.
- Spotlight on Trauma awareness campaign March 2023 with trauma resources developed (Adult F / Molly)
- SAR Initial Chronologies now includes when a person was physically seen or spoken to directly (Adult F)
- Partners encouraged to review their policies and procedures to allow for more flexible approach to engagement (not a '3 strikes and you are out rule') (Adult F)

Questions posed at the Learning Event

What needed to happen to support James to receive services that did not retraumatise? How do we know what 'good' would have looked like?
How does that compare to what actually happened?
PAST How usual, standard, typical were the different aspects of the responses at the time?
PRESENT Would the same response be likely now?
PAST What were the respective supports, constraints and barriers for trauma informed practice?
PRESENT Do these factors still hold today? Have the actions already addressed the issue
What more do we need to do?

Good Practice

5.9. Those who attended the learning event identified that they are at various points in terms of delivering trauma informed approaches and recognised that there was evidence of some good practice. Several services offered outreach appointments rather than expecting James to attend official centres. This was good because it recognised that some of those people who are affected by trauma do not want to attend official centres as it reminds them of those types of places that they remember as younger people. James' sibling and carer told the author that it was also difficult for

James to attend some places as he was likely to know other clients that were attending and on one occasion, he did see a person that had previously been abusive towards him.

5.10. It was also good that there were several attempts to engage with James and services did not discharge immediately upon non-engagement.

5.11. The Mental Health Trust Learning Disability (LD) team had started to build a really positive relationship with James. The dietician within the hospital had a good relationship with James. This all showed that with time, James would respond to services if they could engage with him and recognise the right support that he needed.

Learning

5.12. Professionals at the learning event identified that there was more work to do though and recognised that the following would have been good in supporting James better in offering a more trauma informed approach:

- A key worker role alongside the use of multi-disciplinary team meetings. This would be a person with whom James and his carer and family could get to know and that the person would be able to ensure that other professionals were kept updated.
- A verified history approach that could be shared with other agencies, possibly a 'This is Me' passport type document.
- Recognising other ways and places to engage with a person that does to retraumatise.
- Exploring with a person on first contact, knowing of the requirement for trauma informed approaches, to seek out how a person would find it best to engage and/or attend appointments.
- Ensuring new staff have trauma informed training and that training is not a once offer.

5.13. In order to be able to put the above into practice, professionals identified the need for the following to happen:

- Having a system or framework for professionals to come together where cases do not reach Section 42 Care Act thresholds that multi-disciplinary team meetings and key worker roles are identified in a more supported way rather than because professionals felt it would be good to do.
- Introduction of a 'This is Me' passport for those affected by trauma.
- System flagging for recognising those affected by trauma.
- Review of Trauma Informed approached training requirements.

5.14. It is of note that, on providing some feedback to the family following the learning event, that James' sibling agreed that the use of a key worker would have really helped them. There was also a recognition that the use of multi-disciplinary meetings that they could have attended would also have been very useful.

What has already changed?

5.15. The Mental Health Trust now has an assertive outreach team that are able to offer a more trauma informed approach.

Substance misuse, mental and physical health

5.16. Parity of Esteem is a term used to identify that there is a need to value and manage mental health in the same way as we do physical health. In TSAB area, parity of esteem has been previously explored with actions undertaken accordingly (see below).

5.17. James knew that he used substances as a way of coping and blocking out his traumatic past and current life. He also appeared to understand that his use of alcohol and cannabis was having a negative impact on his physical health. James spent a lot of time in his flat, alone as he was fearful of being abused and he was also embarrassed from wearing a hearing aid and having a cleft lip scar.

5.18. Throughout the last few years before he died, James was offered support from the LD team in various guises and there were good efforts to sustain engagement with James in order to tackle the multiple issues that were affecting him. These were identified as physical health care issues, low mood with some self-harm as well as social issues such as housing and debt management.

5.19. Each time that there were physical health crises, the ambulance service responded appropriately, and, on most occasions, James was conveyed to hospital where he was treated for his presenting conditions as well as a recognition of the need to offer support for his alcohol use. There were occasions where James stated that he was not drinking at that time, but it was not clear that there was a withdrawal management plan in place. It can be dangerous for those who are alcohol dependent to stop drinking suddenly. It is also more likely that without a reduction and management plan in place, that any abstinence will be short lived.

5.20. In the last year of his life, James had some significant hospital admissions where he required critical care and was in hospital for a considerable length of time. These occasions were due to the physical impacts on the body of his continued significant alcohol use. On one of these admissions James discharged himself 15 days after admission, but it is not apparent that any other service knew of this and there is no apparent plan of h ow this would be followed up in the community.

5.21. Unfortunately, it appears that the major factor for James was his alcohol use that was never able to be addressed effectively and ultimately led to his death.

Previous Actions

- Sought assurance from Public Health re commissioning of substance misuse services, longevity of contracts and transition arrangements (Josh)
- Reviewed Alcohol Change Report – analysed the effectiveness of Local Authority vulnerability model against this. Invited Author of Alcohol Change Report to Board (Adult C)
- Safeguarding Vulnerable Drinkers Training introduced in January 2022 (Adult C)
- Health Trusts adopted the ‘Treat as One’ model (Adult D)

Questions for Learning Event

What needed to happen to support James to manage his holistic needs? How do we know what 'good' would have looked like?
How does that compare to what actually happened?
PAST How usual, standard, typical were the different aspects of the responses at the time?
PRESENT Would the same response be likely now?
PAST What were the respective supports, constraints and barriers for managing holistic needs?
PRESENT Do these factors still hold today? Have the actions already addressed the issue?
What more do we need to do?

Good Practice

5.22. As noted previously, it appears that James found it easier to engage with physical health services than other services. To that end there was some good practice seen by the GP practice and the dietician in addressing some of the health care concerns.

5.23. The carer identified one occasion where James was accused of smelling of alcohol and that family stated that professionals would not see him if he had been drinking. Professionals at the learning event did understand and demonstrate that as a dependent drinker, James would have a level of functioning even when he had been drinking and that he would usually always have had a drink, it was only on occasions where James was intoxicated and not functioning that James would not be seen by professionals.

Learning

5.24. Professionals identified that if they had been able to engage James by working in a more trauma informed way and with the above identified learning that this may then have impacted on the elements of engagement in terms of addressing his social and substance issue needs in the way that his physical health needs had been met. It was therefore recognised that much of the above learning is applied here as well.

5.25. In addition, however, it was noted that there was not very much joining up between the hospital and community teams on discharge and that discharge planning did not involve those teams, but it was referral on discharge where ongoing needs were going to be met in the community. It wasn't clear that hospital teams understood the difficulties that community teams were having engaging with James.

5.26. The carer view was quite strong that James had been admitted with serious concerns for his physical health related to his drinking but that he was discharged with no support in place, suggesting that the carer was not aware of the discharge plans.

5.27. Professionals felt that what needed to happen was to have a multi-agency discharge planning meeting. If a multi-agency process had been in place this would have made communication easier as it was noted that there was good practice from each service but that it was not joined up hence the learning in the previous section is again relevant here. Professionals also felt that they needed to

work more collaboratively and get to know the services that others worked in. This will be picked up again in the next section.

What has already changed?

5.28. It has been noted that there has been a lot of progress within this area. There are developments to have a specialist substance misuse social worker within Adult Social Care. Interviews have been conducted and the successful applicant began in post on 18th September 2023. As a result of the learning event networking, a manager from the substance misuse support service was included as part of the interview panel. More importantly that the interface between hospital and community services where there are dependant drinkers has changed. The workers from substance misuse services now work with the hospital alcohol liaison nurses to introduce the person to the community workers at a point before discharge. This is at a time when those with a dependency are being medicated to manage withdrawal and are therefore not drinking. Plans for person centred detox and reduction can therefore commence whilst a person is in hospital and also it means that relationship and trust building can start.

5.29. It is also of note that there were previous concerns (Josh SAR) regarding substance misuse service providers having short contracts and that this flux with workers and documentation was problematic. This is now resolved with contracts being for seven years. This allows for longer planning and other services getting used to the provider and their systems.

5.30. The newer provider not only provides support with substance misuse but use intuitive thinking skills to work on other aspects of life and also offer more appointments away from the centre all of which should encourage more engagement and offers more holistic solutions in working with dependent drinkers.

Multi Agency working and Safeguarding (Self-Neglect)

5.31. These themes have often been addressed individually in previous SARs. For the purposes of emerging learning in this SAR, they are grouped together, recognising in this SAR of how they impact on each other. As a result of previous SARs, the Safeguarding Adults Board and partner agencies have put a lot of energy into improving multi agency responses to self-neglect.

5.32. It does not appear that the safeguarding system was used as effectively as it might have been and there is evidence that each organisation, albeit referring to other services when appropriate, did not appear to work effectively together as a support network around James as has been identified in previous sections.

5.33. There were several recordings by professionals that indicated elements of self-neglect. In the second month of the timeframe, a dietician at the hospital was particularity concerned regarding James' presentation and weight loss. It is really good to see that this resulted in a conversation with the Hospital Trust safeguarding team which led to a referral being raised with social care. This appears to have been sent to the Adult Learning Disability social work team in the local authority but there is no further recording of what happened as a result. It is noted within the chronology for the review that James agreed with the dietician for an adult needs assessment, so this was not progressed as a

safeguarding referral. The social work team clarified this within the learning event.

5.34. Following this, a month later, a safeguarding referral from the police was sent to the local authority. James was not being cooperative with police enquires to proceed to an investigation, however his needs, wishes and feelings were met by the offer of a Care Act (s9)[6] needs assessment rather than section 42 safeguarding enquiry.[7] This is evidence of good use of a making safeguarding personal approach[8] and is likely to have been encouraging for James. The contact and engagement from James was good, but it is not clear how that care needs plan evaluated.

5.35. There were no other referrals from professionals for a safeguarding response to self-neglect during the timeframe of the review. This was despite the concerns that professionals had regarding James' lifestyle and escalating impact of his alcohol use. Four months after the dietician referral there was a call from James' informal carer stating that he could not manage James any longer and that he was spiralling out of control. Advice was given to contact the duty worker; no evidence was received that the carer did this and it was not followed up. The social worker did contact the LD Team in the Mental Health Trust, but James had been discharged the month before; a further referral was made for support. The social worker continued to try and engage with James as well as his informal and family member. Whilst all this was good practice, it may have been a better response to have progressed to a s42 or other multi agency response to self-neglect.

5.36. As a vulnerable dependant drinker, James needed a multi-agency response rather than each agency providing a single agency response, albeit there was recognised single agency good practice. The learning event addressed this element in detail.

[6] **Section 9 The Care Act** Assessment of an adult's needs for care and support.
(1)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. https://www.legislation.gov.uk/ukpga/2014/23/section/9

[7] **The Care Act 2014 (Section 42)** requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. 2014 HM Government The Care Act 2014; https://www.legislation.gov.uk/ukpga/2014/23/resources

[8] **The Making Safeguarding Personal (MSP)** initiative began as far back as 2009 by the Local Government Association and Association of Directors of Adult Social Services[8] to ensure outcome focussed, person centred responses to adult safeguarding, rather than it being a process that happened to people without knowledge. This has since become enshrined in the Care Act (2014) and requires that the adult and /or their representative is part of the safeguarding process.

Previous Actions

- Refreshed and relaunched Self-Neglect Policy, Guidance and Training Workbook (Josh and Adult D)
- Self-Neglect Awareness Campaigns (January 2021 and January 2022) (Josh and Adult D)
- Self-Neglect Training commissioned and ongoing, includes examples on non-typical self-neglect and Josh and Adult F are used as case study examples
- NSAW 2022 – theme of Self-Neglect covered, regional webinar on Self-Neglect and launch of 'What to do about Self-Neglect' animation. TSAB and Independent Voices (LD Advocacy Group) produced an Easy Read Self-Neglect poster and dramatised video of Self-Neglect which is hosted on TSAB's YouTube Channel.
- Multi-Agency Themed Audit Programme: Self-Neglect (Josh), Alcohol Misuse / DA (Adult C), Team Around the Individual (TATI) Cases (Josh and Adult C) – reports routinely taken to Board for assurance.
    - Audit Tool now considers Professional Challenge, effectiveness of Multi-Disciplinary Team meetings (MDT) and recording rationale for decision making (Adult D)
    - TATI Audit Tool developed.
- Causing S42 Enquiries Guidance developed (Josh)
    - Section 42 Enquiry Training (Level 1) course introduced and incorporates Causing Section 42 Enquiries Guidance (Josh)
- Promotion of Professional Challenge Procedure (Josh)
    - Professional Challenge and Professional Curiosity Briefing developed (Josh) – relaunched (Adult D)
    - Assurance sought from partners that professional challenge and professional curiosity is included in single agency training (it is included in all TSAB training) (Adult D)
- Inter-Agency Safeguarding Adults Procedures reviewed (Josh)
- MDT Guidance developed (Adult D) – promoted again (Adult F)
- Views sought from professionals involved in TATI Process of its effectiveness (Adult C)
- Teeswide TATI Guidance and Referral Form developed (Josh)

Questions for Learning Event

What needed to happen to support James around his self-neglecting behaviours? How do we know what 'good' would have looked like?

How does that compare to what actually happened?

PAST How usual, standard, typical were the different aspects of the responses at the time?

PRESENT Would the same response be likely now?

PAST What were the respective supports, constraints and barriers for responding to self neglect?

PRESENT Do these factors still hold today? Have the actions already addressed the issue?

What more do we need to do?

Good Practice

5.37. The professionals who attended the learning event recognised that there was some good practice here in addition to that identified in previous sections and agreed with the author's recognition of this prior to the learning event taken from the reports and chronology. This relates to the dietician recognition of concerns and the Making Safeguarding Personal approach from Adult Social Care.

Learning

5.38. The requirement for multi-agency working has been discussed in both previous sections and applied equally in consideration of a safeguarding response. The most important element of the learning in this section was that the element of self-neglect was not recognised.

5.39. The ambulance service was helpful here in recognising why professionals did not overtly see self-neglect. The usual depiction of self-neglect is where a person and their environment are unkempt. Self-neglect can also include elements of hoarding. In the time frame of the review, it was noted that this is not how James presented. The author had learned from the carer that when James was living elsewhere and was unsupported, that the environment was very unkempt and that, along with the rent arrears had led to the tenancy being ended.

5.40. It only became apparent when the author met with the carer, just how much the carer was doing in support of James. Whilst this will be picked up in the carer section, for the purposes of learning here, it is important to recognise that the carer was cleaning James' flat regularly, doing his shopping so that there were appropriate foods as well as prompting him to manage his personal care. In that way, in essence, the self-neglect was being masked. This was not an issue in some respects as it meant that the impact of the environment and any physical effects of taking care of environment and personal hygiene were not an issue and therefore not leading to harm which was evidence of the positive influence of the carer.

5.41. Where self-neglect was missed, was that the impact of the use of alcohol was having a negative impact on James' body systems and that was where the most harm was occurring.

5.42. The TSAB Self-neglect Guidance[9] is clear regarding the links between self-neglect and substance misuse but does not offer a framework for working around people who self-neglect other than where s42 criteria is reached. There is information within the guidance that identifies that there is most often a benefit for agencies to call together a multi-agency team meeting. Professionals at the learning event, identified that this does not always happen and that it would have been useful in this case. Professionals stated that this is left to the discretion and professional judgment of individual professionals but that there is no formal framework for this to happen.

5.43. It was therefore identified that framework for MDT's around self-neglect would be useful. By sharing information within this framework, it might have been determined that a safeguarding referral was required. Any framework would also be of use in being a vehicle for multi-agency working when a

[9] https://www.tsab.org.uk/wp-content/uploads/2022/10/Self-Neglect-Guidance-V2.3.pdf

case is closed to section 42.

5.44. It was also a feature at this time, that there were a number of newly qualified social workers with very few experienced social workers. Understanding the complexities and nuances of multi-agency working and self-neglect, tends to come with experience. This is being resolved with a recruitment drive to enhance the workforce.

5.45. Whilst there has been a lot of work and improved responses to multi agency working and self-neglect generally, in this case thoughts of self-neglect or calling together professionals to share information within an MDT meeting were not triggered.

Mental Capacity

5.46. Mental Capacity has also been a feature in recent SARs, especially regarding executive functioning and vulnerable dependent drinkers.

5.47. It is known that James had a borderline learning disability diagnosed in the couple of years before he died. There was therefore already a reason to consider his decision-making abilities at each point of a key decision being required and how he needed to be supported to make any key decisions about his care needs and support. There are elements in the records that evidence a curiosity to understand services and the ability to use experience to decide to engage with a service or not. James was not averse to asking questions e.g., he asked a social worker what safeguarding was.

5.48. James had been a dependent drinker for many years and on occasions may have been under the influence of drugs or alcohol at points where he decided upon the services he required.

5.49. There were several agencies who have indicated in their reports that mental capacity was not considered in the way that it should have been, with capacity assessments not recorded and an over reliance on the 'presumption of capacity' principle. There is acknowledgment though, that when it was clear that James did not have capacity, he was treated in his best interests. This was usually when very unwell. Police have indicated that they dealt with James with the knowledge that on most occasions he came to their attention he did not have capacity due to being intoxicated, but that they were aware that this was a temporary position.

Previous Actions

- TSAB Mental Capacity Act (MCA) refreshed (Adult D)
    - TSAB MCA Guidance developed and includes multiple unwise decisions (Adult D) – reviewed (Adult F)
- Legal Literacy Training incorporates Adult F as case study to discuss capacity and risky decisions and Executive Capacity (Molly)
- Executive Capacity Learning Briefing (Molly)

Questions for Learning Event

What needed to happen to support James around his decision making? How do we know what 'good' would have looked like?

How does that compare to what actually happened?

PAST How usual, standard, typical were the different aspects of the responses at the time?

PRESENT Would the same response be likely now?

PAST What were the respective supports, constraints and barriers for assessing mental capacity?

PRESENT Do these factors still hold today? Have the actions already addressed the issue?

What more do we need to do?

Good Practice

5.50. It is good to see that the police understood that on occasions that James came to their attention he was obviously intoxicated and therefore knew that he lacked capacity at those times. The ambulance service had also identified an occasion where they felt that James was refusing to be taken to Accident and Emergency and that he was very unwell. Crews on that occasion sought advice from a clinical lead and made best interest decision to take him to hospital. This was made easier as he was deteriorating at the time. This was good use of escalation and advice seeking to ensure that the Act was complied with.

Learning

5.51. Professionals at the learning event discussed how they applied the Mental Capacity Act and what good practice would have looked like which, as in other sections, leads to learning.

5.52. There was a discussion regarding what the level of James' executive functioning was. James had been drinking heavily for several years and it is clear from information and research, that this would have very likely to have had an impact on his brain.

5.53. The research indicates that decision making and understanding of risk is impaired in alcohol dependant individuals linked to poor working memory processes[10]. A further review of the literature would suggest that an alcohol dependent person will have a disturbance of the mind or brain and may also not have control over their actions, putting the need to drink alcohol above other aspects of life [11]. It was clear that professionals understood that capacity might fluctuate if he was intoxicated but not the wider issues that research would suggest.

5.54. In addition to the impact of alcohol on the brain, James already had a diagnosis of Borderline Learning Disability and therefore that would also need to be taken into account when considering

[10] Brevers, D. et al. (2014) Impaired Decision-Making Under Risk in Individuals with Alcohol Dependence. **Alcoholism: Clinical and Experimental Research** / Volume 38, Issue 7

[11] Jillian Craigie, J. & Davies, a. (2018). Problems of control: Alcohol dependence, Anorexia nervosa, and the Flexible interpretation of Mental incapacity tests. Medical Law Review, Advanced Article. Pp 1–27. Published July 23 2018

his capacity to understand risk but also in his ability to understand what the various services were offering in detail in order that he could make appropriate decisions to engage with services.

5.55. There was one clear example that James did not have capacity to understand the services that the substance misuse service was offering. James' carer told the author that all James wanted was to go to rehab to detox. James was being offered community-based services. James did not understand that he needed to be seen by community services to assess his ability and need regarding rehab.

5.56. This leads to several areas of learning. Generally, the media portrays various celebrities 'going into or having been to rehab'. It may well be that that this has an impact on the understanding of how NHS rehab is accessed. It therefore needs to be identified by professionals, the steps that have to be gone through in order to access rehab services, whether it be because of media influences or other reasons that a person believes they can access rehab by simply asking. It would then be easier if a person did not engage in the first instance to question mental capacity to understand how they will stay motivated and reach their stated goal/s.

5.57. It is therefore executive functioning that is often discussed in terms of where a person says that they want to do something, and it is deemed or presumed that a person has capacity but then they do not carry out what they say they will and want to do. Some experts liken this to a person overestimating their abilities so that it appears that they may appear to understand what the decision is about and that it is what they want but in reality, it is not what happens. In the case of James there were several issues that were likely to affect his executive functioning and many professionals find this element a difficult concept in understanding mental capacity. It is however clear within the Mental Capacity Act Code of Practice[12] that capacity is not a stand-alone one-off assessment if we consider that a person not only is able to apparently understand the information and decision required but that they are able to use and weigh up that information and make the decision based on what they said they wanted to achieve. James was not able to do that. Most agencies had not recorded an assessment of James' mental capacity indicating that there had been a presumption of capacity.

5.58. Presumption of capacity can only be applied in a case where there is a learning disability and alcohol dependency if there is assessed evidence that a person agrees to a decision and then is able to use and weigh that information to understand and manage risk and to achieve the goals that they have set for themselves.

What has changed?

5.59. Mental Capacity assessment continues to be a complex area of work for the majority of professionals. This is borne out by the number of articles, guidance documents and research that can be found across a wide-ranging number of organisations, legal services charities etc. Some of the research acknowledges the complexities that the Mental Capacity Act presents[13]. For this reason,

[12] HM Government. (2007) Mental Capacity Act Code of Practice https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

[13] Kim, S. Y. H., Kane, N. B., Ruck Keene, A., & Owen, G. S. (2021). Broad concepts and messy realities: optimising the application of mental capacity criteria. *Journal of Medical Ethics*, *48*(11). https://doi.org/10.1136/medethics-2021-107571

the safeguarding adults board has produced two new documents[14]& [15] to continue to try and support practitioners in this area of work. Neither of these were available at the time most professionals were working with James.

5.60. In the locality where James lived, there is work ongoing to develop a resource for professionals that will be held within the procedures area online regarding executive functioning. There also prompt cards being developed to increase confidence in application of the Mental Capacity Act. Recommendations will be made to share resources across areas and agencies as there is a lot of work being undertaken to progress the support for professionals with more complex areas of the Mental Capacity Act.

Carer and Family Support

5.61. Albeit that James was placed in care when he was a young child, it appears that he was placed with his sibling and as such, the sibling stayed close helping him and supporting him in the timeframe of the review. He also had contact with his mother, although she did not live locally at the time.

5.62. James also had an unrelated informal carer. Records do not show very much about how or when the carer came to be a carer for James. What was very clear is that most agencies had lots of communication with the carer, especially over the telephone. It is also clear from the narrative that James was happy with this arrangement, but it did not appear to be officially recorded as to the legal status of the carer.

5.63. Although there were no concerns regarding the ability of the informal carer to provide care for James, there is no evidence that there was the offer of any carers assessment, even at the point that James was being assessed under s9 Care Act.

5.64. There were also some agencies who did not identify the carer as a suitable and viable contact option; this led to difficulties in engagement. It became clear that the carer and James' sibling, were very concerned about James but there is not any evidence that they were explicitly listened to and that their concerns were acted upon.

5.65. Through meeting with the carer, the author was able to find out much more detail of not only how they came to be a carer for James but also how much the carer did for James. This is detailed in section four.

Previous Actions

- Assurance sought from partners of how they involve family members in planning, delivery of care and discharge planning (Stephen)
- Learning Briefing for Carers and their legal rights including Lasting Power of Attorneys developed (Stephen)

[14] LEARNING BRIEFING Mental Capacity Act 2005 - Executive Capacity https://www.tsab.org.uk/wp-content/uploads/2023/05/Learning-Briefing-Executive-Capacity-Final.pdf

[15] Practical Guide to Assessing Capacity and Making Best Interests Decisions under the Mental Capacity Act (MCA) 2005 https://www.tsab.org.uk/wp-content/uploads/2021/07/TSAB-MCA-Guidance-2021-v1.pdf

Questions for Learning Event

What needed to happen to support James' family and carers? How do we know what 'good' would have looked like?

How does that compare to what actually happened?

PAST How usual, standard, typical were the different aspects of the responses at the time?

PRESENT Would the same response be likely now?

PAST What were the respective supports, constraints and barriers for supporting family and carers?

PRESENT Do these factors still hold today? Have the actions already addressed the issue?

What more do we need to do?

Good Practice

5.66. As discussed previously many professionals made use of the carer to communicate with James and to try to ensure that James engaged and attended appointments. It was good to see this as it is possibly the reason that James was able to attend appointments at the GP and hospital.

Learning

5.67. The fact that professionals did not know the details of what the carer was doing for James had a significant impact on how professionals understood what James was able to do for himself. This effectively masked some issues and assumptions were made regarding James' abilities. This was possibly because there was no effective engagement in a needs assessment for James.

5.68. Professionals recognised that it would have been good practice to offer both the carer and sibling carer assessments. Professionals recognised that this was something that was often missed in their practice.

5.69. On this occasion it might have been recognised how much the carer was doing and also that the carer on occasions was struggling in what they were offering. It was discovered by the author that the carer did not drive and therefore support was being offered without vehicle support, using taxis for shopping. The carer had indicated to the author that they had informed the family that they would not be able to keep up what they were doing as they were getting older and exhausted by the amount of support that James needed.

5.70. James' sibling was working full time and was unable to support James in the same way as the carer. On occasions where James could not return to his flat either because on discharge his mobility was poor or on the occasion that others were staying at his flat, James did stay with his sibling, but again without any carers assessment being offered.

5.71. Without these assessments it was not understood if there was more support that could have been offered to the carer and sibling in their care of James.

5.72. Offers of Carers assessments are a requirement under the Care Act. It might also have been an opportunity for the carer and sibling to have been listened to in terms of what they felt James needed and should have been included in discharge planning and other plans as they would have been acting in an advocacy role. The carer pointed out to the author that the only reason that the carer knew that James was being discharged was when he had a phone call from James to arrange transport home. This meant that there was no communication regarding any summary of what James required on discharge or any of the ongoing referrals that had been made.

6. Summary and Conclusion

6.1. James was a vulnerable dependent drinker with recent diagnoses of borderline learning disability and type two diabetes. James' vulnerability set against his use of alcohol and his learning disability meant that he required a greater deal of support than was realised by professionals. This was because of the immense support that was in place from an informal carer as well as his sibling.

6.2. Information available to the review from the documents and conversations with family, carer and professionals have highlighted that in order to be able to address his own needs successfully, James required a team around him who were able to work in a trauma informed way, who understood his level of functional decision-making ability and his holistic needs.

6.3. For future working, recognising the nuances of self-neglect in vulnerable dependant drinkers and having a framework for working where the threshold for a safeguarding referral or proceeding to a section 42 enquiry will be crucial to the success of working around a person towards preventing risk and escalation.

7. Recommendations

1. Multi Agency working below the level of Section 42

- TSAB should strengthen the work that has already taken place to promote multi-disciplinary meetings being used and requested across the whole partnership area where the section 42 criteria are not met. The involvement of the person, their families and networks should also be included. A key worker must be named who is the professional that is acceptable to the person and knows the person best.

- In the ongoing review of the Decisions Support Guidance, amendments should be made to include what constitutes a lower lever concern and to promote the use of MDT Meeting Guidance as a framework for lower-level concerns that offers a preventative approach in the vein of family group conferencing.

- The use of the multi-disciplinary meeting approach and links to guidance must be included in the TSAB Self Neglect Guidance.

2. Responses to trauma impacted adults

- TSAB should seek to ensure that the engagement with and use of the Research In Practice Trauma Informed Toolkit is discussed and considered across all of the TSAB localities.

3. Substance Misuse

- TSAB should share the good practice that this report evidences related to the visiting of an SMS worker into hospitals to support the discharge planning process.

- Regarding the Specialist Social Work Role for substance misuse, TSAB should seek information on what is already in place in each locality, share good practice and recommend that a Specialist Social Work role is considered where it is not in place.

4. Mental Capacity

- The resources that are being developed by Adult Social Care in the locality of this review, should be shared and made available across the TSAB area. There should be reciprocal sharing in a 'community of practice' type approach across the TSAB area using previous or existing groups working on supporting staff with the complex areas of the Mental Capacity Act.

- The recently produced resources should continue to be promoted within the learning briefing for this SAR: LEARNING BRIEFING Mental Capacity Act 2005 - Executive Capacity, Practical Guide to Assessing Capacity and Making Best Interests Decisions under the Mental Capacity Act (MCA) 2005. Knowledge and use of these documents should be audited.

5. Carers Role

- A Learning Briefing should be produced regarding the role of informal carers; the importance of understanding the role and offering carers assessments.

- The mandatory offer of carers assessments under the Care Act, should feature in the learning briefing for this SAR. Practitioners should be advised that the offer of a 'carers assessment' should not be a 'tick box' exercise and should be undertaken in a sensitive and needs led approach.

6. Easy Read Resources

- Where assessment or referral identifies a person with low levels of literacy, letters and appointments should be sent using Easy Read versions using local or online tools wherever possible e.g. **https://www.easyreadappointmentletter.co.uk/lincolnshire**

Appendix One **TEESWIDE SAFEGUARDING ADULTS BOARD**

Safeguarding Adults Review- Rapid Review

SUBJECT CASE 1.22 James

Terms of Reference and Scope

1. Introduction

A Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be 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) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may 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.

The Care Act Statutory Guidance 2014 states that in the context of SARs "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and TSAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Agency Review Reports / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary known from referral and scoping.

James was a white British male who was 34 years old at the time of his death. James was found deceased at his sister's home, the cause of his death was alcoholic ketoacidosis. James had spent much of his childhood in foster care and as a result, displayed symptoms of trauma throughout his child and adult life. James had a diagnosis of borderline learning disability that was diagnosed in his adulthood. James also had ADHD and dyslexia. James used alcohol and drugs to manage his trauma; agencies found it difficult to engage with him. James had the support of an informal carer, without whom he would neglect his hygiene. James' mental capacity to not engage was not assessed effectively and a

safeguarding referral in respect of self-neglect was not made. James was hearing impaired and used one hearing aid (he had two, but one ear suffered from ear infections, so he only wore one) James also suffered with type two diabetes for which he was treated with medication and diet. In the last year of his life, James had been admitted to hospital with oesophageal varices which had bled, alcohol withdrawal seizure, acute pancreatitis and abnormal urea and electrolytes. These all relate to damage caused by excessive alcohol consumption. James was offered detox but declined.

3. Decision to hold a Safeguarding Adults Review

The Safeguarding Adults Review Sub-Group of the Safeguarding Adults Board met to consider the case for review. There was an initial delay due to a LeDer review being undertaken. This had already suffered some delay due to the possibility of an inquest. Ultimately a decision was made that although the LeDer review was robust, it did not cover multi agency learning. The outcomes from the finalised LeDer review were that there were concerns regarding the way agencies had worked together and a SAR would be undertaken. As self-neglect was a key feature and there were similarities with another published SAR, the criteria were met for a mandatory SAR. There is some indication that James may have been exploited into criminal activities involving drugs.

4. Scope

The review will cover the period from 1st January 2021 until the date of death (10/12/2021). The date of 1st January is specifically related to a time whereby risk was escalating, and concerns were being raised regarding James. Information will also be sought from agencies regarding background information, key events and interventions at any point prior to the scoping period.

5. Methodology

The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

TSAB elected to use a rapid review methodology that engages frontline practitioners and their line managers. Chronologies collated during the scoping phase along with a brief analysis of practice from each agency, reviewed by the author to identify where learning was emerging within the agreed key lines of enquiry. Agencies are asked to review their own involvement and provide a brief report of their learning and recommendations. A reflective workshop will be undertaken using an appreciative enquiry approach. The workshop will focus on understanding the strengths in the current systems and working towards identifying any areas for further improvement.

6. Key Lines of Enquiry to be addressed

The following case themes that will be addressed and are not in any order of priority or

importance.

6.1. Effectiveness of the Safeguarding System

- What was your agency's involvement in any safeguarding processes regarding James' apparent self neglect?

Please include:

  - Recognition
  - Referrals
  - Information Sharing
  - Planning
  - Escalation

- What would other agencies say about this element regarding your agency response?
- What would you have noticed if the safeguarding system had worked well?

6.2. Mental Capacity Act

- How well was the Mental Capacity Act applied at points where it was or should have been used?
- How did the use of alcohol and drugs impact on James' mental capacity and executive functioning?
- What should good use of the Mental Capacity Act have looked like?

6.3. Engaging with the person

- What strategies and tools does your organisation suggest in order to support practitioners to engage effectively with those who may struggle to accept support from services?
- How effective were the strategies and tools used to engage with James?
- If they were not effective, what might have been a better approach?

6.4. Trauma Informed Care/Approaches

- Please provide an analysis of what your agency did well in understanding any Trauma that James suffered from.
- What is in place that supported your professionals to understand the identified Trauma.
- If your services delivered Trauma Informed Care, what would that look like and what might support professionals to do this effectively?
- What are the barriers to delivering Trauma Informed Care

6.5. Care and Support Needs/Parity of Esteem

6.5.1. How well did professionals understand James' needs for care and support?

- How did James' mental health, trauma and learning disability impact on his ability to manage and address his physical health?

6.5.2. How did James' use of alcohol impact on his mental health and vice versa?

6.6. Protected Characteristics

- How did practitioners evidence the reasonable adjustments required in respect of protected characteristics within the Equality Act (2010)
- How were James' rights protected in terms of abuse in the community?

6.7. Pandemic Impact

Following the national response to the Covid- 19 pandemic, please analyse the impact on James of any changes to services and/or practice during that time.

7. Independent Reviewer

The named independent reviewer commissioned for this SAR is **Karen Rees.**

8. Organisations to be involved with the review:

The following organisations will be asked for Agency Review Analysis Reports:

- The Borough Council
- The Mental Health NHS Foundation Trust
- The Hospitals NHS Foundation Trust
- Integrated Care Board (for coordination of GP report)
- Ambulance Service
- Police
- Drug and Alcohol Provider Service
- Department for Work and Pensions

9. Family Involvement

A key part of undertaking a SAR is to gather the views of the family, involve them in the review and share findings with them prior to publication. TSAB has contacted James' mother and sibling via a point of contact within the local council to inform them of the SAR; they will be invited to take part in the review. James also had an informal carer who will also be invited to be involved where appropriate. The independent reviewer will arrange to make contact with the family and the carer through the contact point.

Project Plan dates:

1.	Initial planning meeting	23/03/2023
2.	Terms of Reference agreed	05/04/2023
3.	Agency analysis returned by	05/05/2023
4.	Review of Chronology and Documentation by Independent Author	05/05-05/06/2023

5.	Distribution of pre workshop report	05/06/2023
6.	Learning and Reflection Practitioners' Workshop	28/06/2023
7.	First Draft Overview report to all workshop attendees and Panel (Governance Group)	31/07/2023
8.	Feedback from Workshop attendees	14/08/2023
9.	Panel (Governance Group) meeting (1)	16/08/2023
10.	V2 Overview report to Panel (Governance Group)	30/08/2023
11.	Panel (Governance Group) meeting (2) to finalise report and build recommendations	TBC likely 20 or 21 September
12.	Final Report and learning briefing circulated to Board members	04/10/2023
13.	Final Report and learning briefing to Board for sign off	11/10/2023