Manchester Safeguarding Partnership

Safeguarding Adult Review – Keith

confidential

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Contents

1. Introduction

Keith was a 63-year-old white British man. He died in an Emergency Department Resuscitation area in September 2021.At the time of his death, the hospital considered that there might be suspicious circumstances as a result of bruising and a pattern of neglect. After a Police investigation, it was determined that the bruising would not have been enough to cause his death and ultimately the death was deemed to be from natural causes: congestive cardiac failure, chronic obstructive pulmonary disease and ischaemic heart disease, with secondary diagnoses of chronic malnutrition and self-neglect. In addition, Keith had a background history of excessive alcohol use.

However, there was sufficient concern about his well-being to prompt the Police to submit a Section 44 referral for a safeguarding adult review (SAR) on the basis of a pattern of self-neglect. The SAR Referral Panel considered the case, and it was agreed that the case highlighted a number of areas of potential learning and it was decided that that a SAR should be undertaken. This SAR covers a period from September 2019 until Keith's death in September 2021.

2. Purpose of the Safeguarding Adults Review

The purpose of SARs is to gain, as far as is possible, a common understanding of the circumstances surrounding the death of an individual and to identify if partner agencies, individually and collectively, could have worked more effectively. The purpose of a SAR is not to re-investigate or to apportion blame, undertake human resources duties or establish how someone died. Its purpose is:

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

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

3. Independent Review

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

4. Methodology

A multi-agency panel of the MSP was set up to oversee the SAR and commissioned an independent author to complete the review. Initial information was sought from agencies involved with Keith and this supported the development of a set of Key Lines of Enquiry. More detailed Information was sought from the involved agencies in the form of a report on the Key Lines of Enquiry. Agencies were also invited to include any other information they considered relevant. This included information from outside the time period identified.

The author was supplied with a series of relevant documents:

- A briefing template from each agency that was completed for the Adult Practice Review Panel (APRP) meeting - this contained basic information on the case and a chronology.
- The notes of the APRP meeting that agreed to proceed to a SAR.
- A report on the Key Lines of Enquiry from each agency involved.

In addition, the evidence was considered in the light of three recent thematic reviews published by MSP:

- *Carers Thematic Learning Review 2021*
- *Self-Neglect Thematic Review 2021*
- *Homelessness Thematic Review 2020*

These have provided important comparative evidence that has been used and referenced in the review. In addition, the MSP *Managing High Risk Together Protocol* was considered.

The following agencies were involved in the process:

- Adult Social Care
- GP / Primary Care
- North West Ambulance Service
- Greater Manchester Police
- GMMH NHS Foundation Trust
- Manchester University NHS Foundation Trust
- ICare Solutions (a care provider)
- Great Places Housing Association

An initial SAR Panel meeting was held in November 2022 to discuss the process, key lines of enquiry and timeline of the review. A Practitioner Reflection Day was also held in November 2022 and contributed a range of thoughts and views on Keith and his care.

All this information was analysed by the report writer and an initial draft of this report was produced and went to the Review Panel in January 2023. Further changes were made over the next two months, and a final draft was completed in February 2022.

5. Family contact

An important element of any SAR process is contact with family. It is known that Keith had a younger sister living in the North West. It was also suggested that he may have had a brother. Contact was sought with his sister but ultimately this was not possible. However, the author did have contact with a staff member from the care agency who had had regular contact with him and was able to provide a more rounded and complete picture of Keith as a person

6. Parallel processes

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

7. Terms of Reference

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

8. Chronology

A chronology of Keith's involvement with services was compiled by MSP from the material in the agency responses. This has been used to develop and support the findings of this document. It runs to over 40 pages of text; therefore, it has not been included in this report for fear of making it unreadable. However, it is available via the MSP to appropriate partner bodies. The next section summarises what is known about Keith both before and during the review period.

9. Background and personal Information

Keith was a 63 year old White British man who died in hospital in September 2021.

On the day of his death health professionals attending Keith's home were concerned about his low blood pressure and the fact that he appeared malnourished. Whilst at the address the patient went into respiratory arrest. An ambulance was called. Keith refused hospital treatment but was assessed by the GP and NWAS to lack capacity to make that decision and therefore he was taken to hospital. Whilst on route he lost consciousness. When he arrived at the hospital, he was described as "grey" and staff could see no signs of life. He was making no respiratory effort and his heart rate was 37. He was not resuscitated at hospital because he had a ReSPECT form which said do not resuscitate.

Hospital staff had concerns about a pattern of bruising on his body and called the Police to investigate whether he was a victim of neglect or abuse. 19 separate injuries were noted on his body (see Appendix 2 for detailed list). However, none of these were felt to be serious enough to have caused his death and most were consistent with an individual who spent much of his time bed bound. Therefore he was considered to have died from natural causes: congestive cardiac failure, chronic obstructive pulmonary disease and ischaemic heart disease, with secondary diagnoses of chronic malnutrition and self-neglect.

The background information available about Keith's life and family was limited. The review was fortunate to have input from a paid carer who visited Keith for half an hour per day. She knew Keith well and described him as a "strong character" who liked Elvis Presley and would often "boogie" to his songs. However, as time went by those days became fewer and further between.

He had at least three siblings, one brother and two sisters. He may also have had a son but this was unconfirmed – certainly there seems to have been no contact if he did have a son. A practitioner who knew Keith said that he would have been embarrassed to be seen by his son in the state he was in the later years of his life.

One of the sisters is still alive; however, the other two siblings are reported to have died within a day of each other in August 2019. Keith was very close to his brother and was known to have lived with him at some point in his adult life and to have visited him when he was in a care home at the end of his life. His death appears to have effected Keith very badly. Practitioners commented that there was a "massive change" in Keith after the bereavement. Adult Social Care recognised the need for support around this and offered to signpost him for bereavement counselling. This loss may have contributed to his decline during the next two years.

Nothing is known of his work history, but Keith had a long history of involvement with the criminal justice system. He had convictions for theft, burglary, handling stolen goods, deception and Breach of the Peace. The last report about Keith in Police records is in 2018 when there was a complaint about Keith harassing a neighbour (this was not pursued).

A picture emerges of Keith as someone who had an alcohol use disorder. This was not formally diagnosed and Keith never seems to have attended an alcohol service. He was described as not wanting conversations about his alcohol use and on one occasion Keith shut down a conversation with his Carer about the possibility of attending Alcoholics Anonymous. Nonetheless, Carers were clear that this was having an impact on his care, particularly his evening care. His alcohol consumption may have declined towards the end of his life, although even this is uncertain.

The alcohol was being bought for him in part by his Carers. However, it was also being bought by a man he sometimes described as his "uncle". The nature of this relationship is uncertain; however, there were suspicions about financial exploitation which led to a safeguarding concern. This man appeared to have had Keith's bank card, possibly against Keith's will. This situation had not been clarified at his death.

Keith was also a smoker, and the risk of fire raised concerns at one point in the review period and initiated a home safety visit from the Fire Service. COPD was also a contributory factor to his death.

However, the main concern in the last years of Keith's was his declining health and inability to care for himself. Most of the chronology is focused on the challenges that services had managing his health.

For example, at the beginning of the review period (September 2019) a home visit from the GP showed that Keith was underweight and appeared to have lost more weight since he was last seen. His Body Mass Index was already dangerously low. He reported drinking Fortisips regularly and eating sandwiches that his Carers made for him but he refused to see a dietician. He said that he was aware that further weight loss could result in serious illness/death. He denied actively wanting to die but wasn't bothered about dying soon. He denied low mood. He was described as looking "cachectic" on this visit - physical wasting with loss of weight and muscle mass. His affect was described as "blunted" though he did engage with the GP. There were several cans of lager by his bed but the flat was clean and tidy. He was assessed as having the mental capacity to decline the dietician referral.

He was in receipt of care from a care agency and had Carers coming in on a daily basis to help with meals and cleaning. However, the care notes highlight a consistent pattern of refusal of food, drink and care.

Over the next two years the challenges of providing him with health and social care continued and as a result his physical decline also continued to the point of his death. Some examples from his care highlight these challenges:

- October 2019 - A Carer arrived and went to make Keith's dinner. He became visibly angry and said he hated her.
- January 2020 - He did not attend a chest appointment and, after a consultation with his GP, he was clear that he did not want a further referral.
- March 2020 - He was called to make him aware of the Covid situation but he said that he rarely went out anyway.
- August 2020 - Telephone call from Keith's Carer to Social Work Duty to raise concerns that Keith was not eating or not taking his prescribed medication.
- February 2021 - Keith declined a flu vaccine
- June 2021 - Keith declined a CMHT assessment and asked for it to be rearranged.
- August 21 - a home visit by his GP and District Nurse identified evidence of self-neglect. Keith was in bed and covered in faeces. The walls were tobacco stained. Keith was extremely underweight – "skin and bone". His clothes were ripped and there were cans of beer by the bed He had a pressure sore on his left hip. He initially refused to be cleaned up but the District Nurse was able to convince him.

Ultimately towards the end of this period, Keith had had a fall from bed which had led to a bleed on the brain. His GP had concerns about his cognitive functioning and that there was variability in his cognition. However, five days later Keith declined further, was taken to hospital and sadly died.

10. The Key Challenge: Difficulty of Engagement

Keith received help from many agencies. Nonetheless, the core challenge with Keith was that he was very difficult to engage into a structured programme of care. Professionals were aware of his needs and, within the framework of their disciplines, were attempting to help him. However, on multiple occasions he refused to engage with efforts to offer him help. The NHS Trust commented: “the biggest challenge was engagement”. In the year prior to the review he had missed multiple appointments and declined re-referral to respiratory services. He was difficult about accepting pressure relieving equipment and even Carers themselves. He was regularly abusive to staff and declined nursing input. It is worth noting however, that he did engage more positively with staff from his Housing Association which suggests that he was more likely to respond to certain types of approach.

Over the period of the review there are many examples of him not engaging with care e.g.:

- September 2019 – health services try and contact him three times without success about a prescription.
- October 2019 - Keith told a Social Worker that nothing was wrong and terminated a call.
- December 2019 - Failed home visit by GP as Keith was asleep and declined the visit.
- April 2020 - Adult Social Care made four attempts to complete annual review by phone…the number was not connecting.
- August 2020 Carers were concerned that Keith was not eating, declining medical treatment, and refusing to allow them to support him.
- September 2020 - Keith had started to decline full Pressure Area Checks, also refusing the use of a gel pad despite an explanation of the benefits.
- November 2020 - Very resistant to going to A&E about a serious cough. Keith then refused to get in an ambulance that had been sent.
- December 2020 - He did not attend an outpatient respiratory appointment. A letter from the Consultant stated that he had previously written to Keith in December when he failed to attend multiple appointments and following a further referral, they had provided further appointments and included hospital transport, however Keith still did not attend. The letter states, therefore, that they were unable to offer any further cancer appointments and discharged him back to the care of the GP.
- February 2021- Keith declined the flu vaccine and also declined further dietitian input.

- April 2021 - Keith declined an increase in Carers' visits stating he 'only wanted Carers to buy alcohol and cigarettes for him.' He continued to decline all personal care.
- April 2021 - Keith stated 'he is sick of women visiting him and nagging him, he wishes to continue to smoke in bed and (refused) a dynamic mattress'.
- July 2021 - Keith cancelled a planned home visit. He agreed to the Social Worker ringing him again to rearrange.
- August 2021 - Keith declined CMHT assessment, he was described as "brittle and dismissive".
- August 2021 - Keith saw a District Nurse get out of a car and was heard shouting 'go away' out of the window, he then continued to swear at the Nurse.
- September 2021 - Visited and found to be saturated with urine, declined personal care, aids for repositioning and admission to hospital.

These incidents have been listed at length to emphasise the degree and regularity of the problems involved in Keith's care. However, even this list is just a small proportion of the potential examples. All of the professionals involved with Keith recognised that he was difficult to engage in care.

However, as the CMHT commented: *"there was no triangulation of the reason for this… consideration of any cognitive factors which may have been influencing his engagement and that a more assertive approach may be indicated to establish that there were no depressive features influencing Keith's presentation, particularly given the GP highlighting the presence of suicidal ideation."*

The impression is that agencies continued to attempt to engage with Keith in the same way – making an appointment, turning up and hoping he will accept contact this time. This seems to be a case of "professional optimism" triumphing over the need for "professional curiosity".

So far these comments have focused on the need for a changed relationship between Keith and the professionals involved in his care. However, they also highlight the need for a specific published procedure to guide professionals in dealing with client non-engagement. Keith's case history highlights that to make that procedure useful it will need to provide guidance on:

- how to judge the level of risk or vulnerability that warrants ongoing, assertive action;
- how to practically intervene with hard to engage clients; and
- how to escalate these concerns and where they should be escalated to.

This process, whether single agency or multi-agency, would also benefit from guidance on what techniques work with hard to engage clients. This is an under-developed field. The SAR author looked for national guidance on this issue as part of the drafting of this report but could not find an overarching guidance document. Reports such as "The Keys to Engagement" (mental health)[1] and "The Blue Light

[1] https://www.centreformentalhealth.org.uk/sites/default/files/keys_to_engagement.pdf

Project" (alcohol misuse)[2] have addressed this issue with specific client groups but there is no single guidance document. Whether at a local or a national level, such guidance will be a vital support to those working with vulnerable and difficult to engage clients. (It should be noted that the national SAB Manager Network is currently developing guidance on working with difficult to engage clients. This is not complete but may fill this gap.)

Keith is not unusual in presenting difficulties of engagement. The MSP *Carers Thematic Learning Review 2021* identifies the same issue: *The challenges of supporting adults who do not consent to treatment or support and who are judged to have the capacity to make those decisions in an informed way…* It also recognises failures to escalate these individuals.

The same review goes on to comment on: *a sense that their persistent refusal of offers of care and support were perhaps too readily accepted, perceived and interpreted by practitioners as 'non-compliance' rather than as a form of self- neglect, which was a product of the adults' adverse life experiences, poor quality of life and very challenging day to day living*.

The *Homelessness Thematic Review* likewise comments that: *When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; loss and trauma often lie behind refusals to engage. Contact should be maintained rather than the case closed, in an effort to build up trust and continuity.*

Therefore, the following sections explore what works with this client group. The key learning points are summarised in section 19.

11. What works: a community pathway

A range of evidence now identifies "what works" with difficult to engage chronic dependent drinkers. This is most clearly summarised in Alcohol Change UK's Blue Light project manual.[3] However, the Office of Health Improvement and Disparities' (formerly Public Health England) forthcoming clinical guidelines on alcohol, the Carol SAR from Teesside and the Alan SAR from Sunderland provide examples of other endorsements of this approach.

At its core is:

- A care package centred on intensive assertive outreach.
- A multi-agency management group to guide and support the work.
- The willingness to be consistent and persistent and to allocate time to the task

[2] https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project

[3] For transparency purposes it should be noted that the author of this report is the co-author of the Blue Light project manual.

12. What works: Assertive outreach

The Carers Thematic Review comments that *Working with adults who self-neglect, and their families, takes time and requires a slow and careful approach where the aim should be to develop a trusted relationship with the adult and family as a basis for working together.* This is a good description of assertive outreach.

Keith would have benefited from an assertive outreach approach which would have attempted to build a relationship with him in order to understand what lay behind this refusal of care. Is it bereavement, trauma and consequent depression? Is it shame about the way he is now living? Is it fear that intervention might interrupt his supply of alcohol or cigarettes? Is it concern that he may lose his home and independence?

An assertive outreach approach is built on the recognition that with complex clients such as Keith, agencies are going to need to sustain the relationship rather than expecting Keith to be able to do that. This will require an approach that is:

- Assertive – using home visits
- Focused on building a relationship
- Flexible – client focused – looking at what the client wants
- Holistic – looking at the whole person
- Coordinated – linking with other agencies
- Persistent and consistent.

Once professionals have a better understanding of what is behind this pattern of non-engagement, they can begin to think about ways in which his needs can be better addressed. This might have ranged from using practical approaches such as putting up a reminder notice board with appointment times and pictures of workers who were going to visit through to an outreach worker being present at appointments with him, the use of motivational interviewing and on to a better understanding of how the Mental Capacity Act could be used in his case.

It might be argued that if someone is capacitated, they can choose to disengage. However, the report of *The 2013 Mental Capacity Act 2005: Post-Legislative Scrutiny*, criticises the use of the Act in this way: *The presumption of capacity…is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm.*[4] The MCA Code of Practice repeatedly highlights the need to assist capacitous people with their decision making[5] or to undertake *further investigation in such circumstances.*[6]

Keith is likely to have benefited from the availability of specialist assertive outreach staff who can work with this client group. His engagement with Housing Association staff again suggests that he would respond to more positive approaches.

[4] Mental Capacity Act 2005: Post-Legislative Scrutiny 2013 105
[5] Mental Capacity Act 2005: *Code of Practice 1.2*
[6] Mental Capacity Act 2005: *Code of Practice 2.11*

13. What works: Care Co-ordination and Multi-agency Management

Keith's care would have benefited from clear leadership: a care coordinator and multi-agency management. No one worker appears to have taken on the role of coordinating and leading his care and multi-agency management of his care only really began late in the process.

The need for a care coordinator was acknowledged in the practitioners' workshop and in the agency reports as something that would have benefited Keith. This could have emerged from the safeguarding process but didn't. A clear policy on working with difficult to engage clients might have driven the appointment of a care coordinator. Regular multi-agency meetings could also have driven this. Whichever way this was approached, Keith would have benefited from someone who could step back from the day to day interventions and see the overall picture of the problems he presented and considered ways in which this could have been better addressed.

Keith would also have benefited from regular multi-agency discussion. There is clear and positive inter-agency *liaison*. However, there is a gap in multiagency *collaboration* to support Keith. This was acknowledged during the last 15 months of his life.

- August 2020 – a referral to a multi-agency meeting was suggested.
- September 2020 – an MDT meeting is mentioned in the notes but this appears to have been staff at his GP practice.
- March 2021 - A duty Social Worker advised a Nurse to arrange a Multi-Disciplinary Meeting as Keith's needs were health related. The Nurse agreed to request a Care Navigator to assist in arranging this.
- April 2021 - A multi-agency meeting was arranged and then cancelled. It was planned to rearrange it.
- May 2021 - Keith's Social Worker called the District Nurse to ask about the rearranged meeting but was told it would not take place because Keith had been prescribed anti-depressants and that his mood had improved.
- August 2021 - The Social Worker asked Keith's Nurse to arrange a Multi-Disciplinary Meeting to discuss and co-ordinate services to support or encourage Keith to accept medical treatment.
- September 2021 - The Ambulance Service were told that the Social Worker and GP were going to organise an MDT meeting in order to get the right care in place for Keith.

The notes suggest that a multi-agency meeting never took place. This was acknowledged by agencies and practitioners as a gap in Keith's care. This could have been addressed in a number of ways: as part of a safeguarding process; by having a clear policy on dealing with difficult to engage clients; by having a policy on calling a multi-agency meeting; through referral to an existing multi-agency group; or through individual initiative by another professional. Whichever way was chosen, this is a process that could have benefited Keith.

The *Carers Thematic Review* recommended that: *MSP partner agencies should creatively promote and reinforce the role and value of multi-professional meetings to manage complex cases.* The *Homelessness Thematic Review* also repeats this message and it is again reflected in the findings of this review of Keith's care.

14. What works: Safeguarding

Keith was an adult with care and support needs and the Care Act could have provided a framework for addressing the challenges posed by Keith as well as protecting him from further harm. Five safeguarding concerns were raised about Keith during the review period.

- June 2020 - the CMHT raised a safeguarding concern due to self-neglect. The Social Worker who assessed Keith was unable to determine whether he lacked capacity and requested an onward referral to mental health services for further assessment and support in management. It is unclear if any other action was taken as a result of this concern.

- March 2021 - The District Nursing team raised a safeguarding concern because Keith was not eating and was refusing medical intervention. This referral was screened by the Multi Agency Safeguarding Hub and referred to the Locality Social Work team to progress. According to the records, a joint District Nurse/Social Worker visit was carried out in April 2021 to gather more information on this enquiry. However, Keith would not engage with the professionals. It appears that it was agreed at this point that a multi-agency response and approach would be required. A Social Worker was allocated to participate in multi-agency meetings. A date was arranged for a virtual MDT meeting, but this was cancelled after Keith was assessed by his GP and prescribed anti-depressants.

- May 2021 - A safeguarding concern was raised by a District Nurse following a discussion regarding finances with Keith. His Social Worker advised she would take over this issue.

- July 2021 - A further safeguarding concern was raised by the District Nurse in consultation with the Care Agency for possible financial abuse. Keith had alcohol purchased for him and a “friend” had his bank card in order to make this purchase. According to the records the Social Worker could not progress this enquiry due to non-engagement. However, in August 2021, the allocated Social Worker requested a multi-agency meeting to be coordinated by the District Nursing team due to ongoing safeguarding concerns around Keith not accepting care provision and self-neglect. This request was not progressed as the team informed the Social Worker that Keith had been deemed to have mental capacity around his medical treatment and accepting care.

- September 2021 – just a few days before Keith’s death, the Ambulance Service raised a safeguarding concern for self-neglect following their attendance at a fall at his home, an incident which had involved a number of other agencies.

There were also missed opportunities to raise safeguarding concerns

- September 2019 – A home visit by his GP identified that Keith appeared to have lost more weight since he was last seen. His BMI was already dangerously low.

He didn't wish to see a dietician and was aware further weight loss might result in serious illness or death. He denied actively wanting to die but "isn't bothered about dying soon". There were several cans of lager by the bed. The flat was clean and tidy and Keith was seen as having capacity to decline dietician referral.

- March 2020 - his GP reported that Keith felt fed up but was getting support from his "uncle" who lived nearby and brought food. He was concerned that someone had recently tried to break into his flat through the front door. It is commented in the notes that this was a missed opportunity to consider a safeguarding referral in light of his vulnerability and the reported break in.

Keith's care appears to echo concerns about the use of the safeguarding framework in MSP's *Self Neglect Thematic Review* (2021). This looked at the care of three individuals with care and support needs who also had alcohol use disorders. This identified that: *For all three individuals there were a number of concerning incidents which should have resulted in a full adult safeguarding investigation and a multi-agency strategy consideration...* (3.24) In particular, it comments that:

- *The apparent lack of a coordinated safeguarding response to all three individuals hindered the fullest multi-agency consideration (3.25).*

It goes on to say that: "*There are a number of examples where one agency identified the risks and sought to prompt a full safeguarding response…but this did not come to fruition..." (3.26)*

The lack of a full adult safeguarding investigation is a key concern with the care of Keith. This could have led to a multi-agency strategy meeting which this review has already identified as a missing element in Keith's care.

The Thematic Review goes on to say that: *If an agency has concerns that a safeguarding matter is not being handled adequately…it is good practice to escalate this…An escalation process allows professionals and agencies to challenge the safeguarding team or system if a decision of no further action is considered inappropriate by the referring agency.* (3.27) Again this step was missing in the care of Keith.

15. What works – using the Mental Capacity Act

Given that Keith was frequently refusing interventions that might have improved his health or well-being, questions about his mental capacity to make those decisions are important. His capacity was considered or assessed on at least seven or eight occasions.

- September 2019 - his GP assessed that he had the capacity to decline a dietician referral.
- June 2020 - a Social Worker assessed Keith but was unable to determine whether he lacked capacity and requested an onward referral to mental health services for further assessment.

- November 2020 - he was discharged from the District Nursing caseload as he was declining visits. The chronology indicates that there were "no concerns regarding capacity".
- December 2020 - Keith declined to be weighed by a Nurse: his capacity to do so was "presumed".
- Mid-2021 - a series of steps were taken to assess Keith's capacity. In April he declined to have dressings changed. As a result the Nurse discussed mental capacity with Keith's Social Worker. Consideration was given to the GP undertaking this assessment but the GP made a referral for a formal *mental health/capacity assessment*. It was also recognised that there was a need for an Advanced Care Plan, as the situation was likely to deteriorate. A Nurse agreed to do this. In early August 2021, the CMHT attempted to assess him, but Keith requested staff to leave. The CMHT reviewed the case and determined that they were not the appropriate team to undertake this assessment as the primary concerns were around physical health needs.
- August 2021 - a joint visit by a GP and Nurse, found that Keith had deteriorated clinically. At this point the GP decided to request an emergency capacity assessment (it is not clear who from).This began a discussion about a ReSPECT form[7] which was duly completed.
- September 2021 - Care Staff and a Social Worker found him fallen out of bed with his leg entangled in the bed bar. This led to a considerable debate between professionals as to whether Keith had capacity to refuse to go to hospital. The Social Worker and Ambulance Paramedics felt he lacked capacity. His GP consulted various parties and decided that Keith did lack capacity. However, when an ambulance returned paramedics had doubts about this decision and further discussion ensued that resulted in Keith not being taken to hospital.
- September 2021 - Keith's health deteriorated further and at this point it was assessed that he lacked the capacity to refuse hospital intervention and he was taken to hospital but died soon after.

Assessing Keith's mental capacity was not a straightforward task. For example, Keith did not have a diagnosis of a mental disorder or cognitive impairment which may have made the assessment of his capacity more challenging. Indeed his GP turned to Mental Health Services for help with the capacity decision. A more particular problem is whether Keith met the criteria regarding his ability to take a decision i.e. can he understand, retain and use information and can he communicate a decision? Again, this was challenging with Keith who, at times, very clearly articulated his unwillingness to engage with treatment and care.

Nonetheless, Keith's care appears to echo concerns about the use of the Mental Capacity Act in the *Self Neglect Thematic Review*. This raises concerns about the assessment and understanding of the Mental Capacity Act stating that: *Further development work is required across all agencies as to when and how to assess more complex considerations of mental capacity.*

[7] A person's ReSPECT form includes recommendations about emergency treatments that could be helpful and should be considered, as well as those not wanted by or that would not work for the patient. It includes a recommendation about CPR, but that may be a recommendation that CPR is attempted, or a recommendation that it is not attempted.

The Carers Thematic Review comments on the need to *support informed but realistic choice and control, especially in cases of self-neglecting behaviour, but (to) balance this carefully with duty of care and safeguarding.* The *Homelessness Thematic Review* comments that: *Research and SAR evidence indicates that professionals often prioritise and emphasise a person's autonomy rather than respectfully challenging why an individual is refusing care and support.* This balance was still not being achieved in the care of Keith.

In particular these Thematic Reviews echo three themes that reappear in this review:

- The confidence of professionals with using the Mental Capacity Act, particularly in complex cases
- The importance of recognising the range of impacts on someone's mental functioning when assessing their mental capacity
- The importance of recognising executive capacity with this group.

There does appear to be a lack of confidence in using the Mental Capacity Act: professionals attempt to pass the task of assessment to other agencies. This again reflects the *Carers Thematic Review* which comments on *confusion about who was responsible for making judgments about mental capacity in the provision of routine physical healthcare.* The *Homelessness Thematic Review* echoes this concern.

Although Keith did not have a formal diagnosis of a mental illness or cognitive impairment, that is not a requirement of the Mental Capacity Act. This is particularly important with people with alcohol problems who may have many more hidden or subtle impacts on their mental functioning. To reflect the Self-Neglect Thematic Review: *"it is well understood that a chronic tendency to abuse alcohol can eventually impact upon a person's cognitive functioning and memory. Some will go onto to develop Korsakoff's syndrome. This was not investigated…Given the above… it could not be safely assumed by professionals that any of the individuals subject to this review had mental capacity at all times particularly when intoxicated…"* This same consideration needed to apply in the case of Keith. A number of factors may be impacting on his cognition: e.g. his drinking, but also his COPD and falls. He may be depressed because of his brother's death. These impacts need to be understood when considering his mental functioning.

In assessing capacity with vulnerable and self-neglecting individuals like Keith it is also important to consider executive function. (This is also highlighted in the *Carers Thematic Review*). The Teeswide Carol SAR talks about the need to look at someone's "executive capacity" as well as their "decisional capacity". Can someone both *take* a decision and *put it into effect* (i.e. use information)? This will necessitate a longer-term view when assessing capacity with someone like Keith. Repeated refusals of care should raise questions about the ability to *execute* decisions. The draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function and to consider repeated failed decisions when assessing capacity.

Far more consideration could have been given to how the Mental Capacity Act was used with Keith. Indeed, ultimately, consideration could have been given to building a case for action under the Human Rights Act 1998, e.g. Article 2.[8]

Again the lack of a clear multi-agency framework and clear leadership around Keith's care would have hindered the use of the Mental Capacity Act. Within a multi-agency meeting, professionals could have considered his mental capacity from a number of angles and have professionally challenged situations in which they feel that the approach was inappropriate.

16. What works – Addressing alcohol use disorders

As has been said, Keith had an apparent pattern of excessive alcohol use. It is likely that this had a significant impact on his life and on the health problems that led to his death. It may also have impacted on his cognitive functioning through direct alcohol related brain damage or possibly through intoxicated falls.

Keith was not formally diagnosed with an alcohol use disorder but the chronology gives a picture of alcohol's role in his life.

- September 2019 – the GP notes "Several cans of lager by the bed… Alcohol dependence syndrome review. Still drinking excessively but declines… input."
- October 2019 – he claimed that he had cut down to 2-3 cans of lager a day but a neighbour provided a contradictory picture and his Carers were being asked to buy him alcohol. Keith could become verbally aggressive if they refused. His Social Worker discussed a visit from the Alcohol Liaison Nurse.
- October 2019 – Keith continued to drink alcohol reporting it was all he had left.
- November 2019 – Keith was still drinking 3-4 cans lager a day and discussed reducing alcohol.
- February 2020 - Keith reported drinking 8 cans or more of mid strength lager and said he would like help to cut down his drinking. There was concern that alcohol was impacting on his medication. A follow-up was arranged with a Substance Misuse Nurse who discussed support in reducing alcohol intake.
- March 2020 – He was drinking 4 cans a day and didn't want to reduce further but had a telephone consultation with an Alcohol Nurse due to Covid. He said the amount he was drinking had reduced.
- August 2020 - Carers reported supporting Keith to the shops but noted he only bought alcohol and no food.
- April 2021 – His alcohol intake was reported to be 24 units per week.
- August 2021 - Evidence of alcohol consumption with cans by the bed.
- September 2021 - Alcohol intake was reported to have reduced over recent weeks.

[8] Department for Constitutional Affairs - A Guide to the Human Rights Act 1998: Third Edition – 2006: https://webarchive.nationalarchives.gov.uk/+/http:/www.dca.gov.uk/peoples-rights/human-rights/pdf/act-studyguide.pdf

What is also clear is that Keith was resistant to engaging with help on his alcohol problem. As such he falls into the category of "change resistant dependent drinkers" described in Alcohol Change UK's *Blue Light* manual. (It should be noted that the *Self-Neglect Thematic Review* endorses the *Blue Light* project approach.)

Practitioners commented that local specialist Alcohol Services do not work very well for this group. They are described as requiring clients to be motivated to address their drinking and ready to self-refer. This was not Keith's situation. Practitioners described a need for specific *alcohol engagement workers*. There were also comments about the length of waiting times for alcohol detoxification in the community.

It is interesting to note that Manchester City Council has a Statutory Substance Misuse Team which has 17 Social Workers, of which five are Senior Social Worker posts. The Seniors focus on the most complex and high-risk cases. Their aim is *to achieve better outcomes and better lives. This will involve understanding why a person is behaving in particular ways and will inevitably identify many dependent drinkers with cognitive impairment*. It is surprising that Keith was not referred to this service. Discussions with the Service's Manager suggested that Keith would have been an appropriate client.

Beyond enhanced services Keith's alcohol use highlights a need for accurate assessment and recording of alcohol consumption and associated harm. In most of the entries quoted above Keith's alcohol consumption is described in terms of "cans". This is not helpful. 3-4 cans, for example, could equate to a level of consumption slightly above the recommended limit or to a level that is likely to equate to dependent drinking (over 100 units per week of high strength lager). Recording of alcohol consumption should be in units of alcohol.

The impact of this drinking will also vary greatly dependent on his body mass index (BMI) and nutritional status. Keith was very low BMI and this will have impacted on the way alcohol affected him. Therefore, it is important both to record accurate data on quantity and to contextualise information about his drinking.

At the very least, this is a reminder of the importance of robust alcohol screening processes to ensure that any alcohol-related risk is identified and highlighted. In accordance with NICE Public Health Guidance 24, professionals working with the public need to be alert to the possibility of alcohol use disorders and should be routinely asking the AUDIT questions and using professional curiosity to explore this issue. Best practice would ensure that the AUDIT alcohol screening tool[9] is routinely being used by all relevant professionals, whether in Primary Care, Mental Health Services, Adult Social Care, Housing or any other adult service.

[9] Alcohol Use Disorders Identification Test (AUDIT) (auditscreen.org)

17. Additional point - Smoking

Keith was a regular smoker. This is a sub-theme in this SAR but it is reminder that agencies should be considering the impact of smoking from two perspectives:

- the heightened risk of accidental fire and fire death in people with alcohol problems who are also smoking; &
- the prevalence of smoking and its specific impact on the health of people with alcohol problems.

70-80% of dependent drinkers smoke[10] and approximately 50% of domestic fire deaths are related to alcohol use.[11] Perhaps more significantly, Professor Michael Preston-Shoot's 2020 *Analysis of Safeguarding Adult Reviews* examined 231 SARs from 2017-2019, 19 of the deaths involved were due to fire.[12] This highlights the importance of a focus on fire safety with vulnerable clients. In Keith's case clumsiness due to arthritis (he couldn't use his kitchen tap) would have exacerbated this problem. As a result in 2019 he had a home safety visit from the Fire Service; they issued some fire-retardant bedding and a sofa throw. This is good practice.

Smoking causes more specific problems for high-risk drinkers because it worsens many of the diseases associated with alcohol use e.g. oral cancers, liver disease and coronary heart disease. Smoking may contribute to the depletion of vitamin B1 from the body through reduced appetite, increasing the risk of cognitive impairment. Certainly smoking was a contributory factor in Keith's death.

Expecting a dependent drinker to immediately give up smoking may be unrealistic. Steps were taken by health professionals to offer smoking cessation; however, it is now possible to help drinkers switch to vaping. Promoting vaping may be an opportunity to both address potential health problems and reduce fire risk.

18. Additional point - Covid 19

The majority of the period under review was during the Covid-19 restrictions. This did impact on his care. Adult Social Care commented that: *Government guidelines for visits to the community during the Coronavirus pandemic were in place. As a result, telephone contact was with Keith at a time when his needs may have been changing and risks may have been increasing.* Other agencies will have experienced similar challenges and it would have been harder to have pursued an assertive outreach approach in this period. This needs to be acknowledged when considering Keith's care.

[10] Office for National Statistics – Drinking Habits among Adults 2012
[11] fire deaths :: www.forensicmed.co.uk
[12] Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 (local.gov.uk)

19. Key Learning Points

Any comments on the learning from Keith's care need to be prefaced by a recognition that most of the period under review was at the height of the Covid-19 restrictions. This may have impacted on the interventions he received and needs to be acknowledged when reading these comments.

Keith received positive help from many agencies. Nonetheless, the core challenge with Keith was that he was very difficult to engage into a structured programme of care. Professionals were aware of his needs and, within the framework of their disciplines, were attempting to help him. However, on multiple occasions he refused to engage with the help offered.

The impression is that instead of trying to find new ways of addressing this challenge, agencies continued to attempt to engage with Keith in the same way – making an appointment, turning up and hoping he will accept contact this time. As was said earlier, this is a case of "professional optimism" triumphing over the need for "professional curiosity".

This highlights the need for a procedure to guide professionals in dealing with client non-engagement. Keith's case history highlights that to make that procedure useful it will need to provide guidance on:

- how to judge the level of risk or vulnerability that warrants ongoing, assertive action;
- how to practically intervene with hard to engage clients; and
- how to escalate these concerns and where they should be escalated to.

A range of evidence now identifies "what works" with difficult to engage dependent drinkers. At its core is:

- A care package centred on intensive assertive outreach.
- A multi-agency management group to guide and support the work.
- The willingness to be consistent and persistent and to allocate time to the task.

Keith would have benefited from an assertive outreach approach which attempted to build a relationship with him in order to understand what lay behind this refusal of care. Once professionals have a better understanding of what is behind this pattern of non-engagement, they can begin to think about ways in which his needs can be better addressed.

Keith's care would have benefited from clear leadership: a care coordinator and multi-agency management. No one worker appears to have taken on the role of coordinating and leading his care and multi-agency management of his care only really began late in the process.

This was acknowledged as a gap in Keith's care. This could have been addressed in a number of ways: as part of a safeguarding process, by having a clear policy on dealing with difficult to engage clients, by having a policy on calling a multi-agency meeting, or through referral to an existing multi-agency group, or through individual

initiative by one or other professional. Whichever way was chosen, this was a process that could have benefited Keith.

Keith was an adult with care and support needs. Five safeguarding concerns were raised about Keith during the review period. There were also other missed opportunities to raise safeguarding concerns

Keith's care appears to echo concerns about the use of the safeguarding framework in MSP's previously published *Thematic Reviews*. For example, Finding 2 of the *Self-Neglect Thematic Review* was that: *There are apparent challenges to the adult safeguarding system which mean that a full multi-agency response is limited.* The *Thematic Review* identified concerns about the apparent lack of a coordinated safeguarding response and that this hindered the fullest multi-agency consideration. The lack of a full adult safeguarding investigation is also a concern with Keith. This could have led to a multi-agency strategy meeting which this review has already identified as a key missing element in Keith's care.

The *Self-Neglect Thematic Review* goes on to say that: *If an agency has concerns that a safeguarding matter is not being handled adequately…it is good practice to escalate this…An escalation process allows professionals and agencies to challenge the safeguarding team/system if a decision of no further action is considered inappropriate by the referring agency.* (3.27) Again this step was missing in the care of Keith.

Given that Keith was frequently refusing interventions, questions about his mental capacity to make those decisions were important. His capacity was considered or assessed on at least seven or eight occasions. These assessments again reflect concerns in the *Thematic Reviews.* In particular, three themes emerge:

- Recognising that "impairments of the mind or brain" do not have to be diagnosed mental disorders, and that people with alcohol problems may have more hidden or subtle impacts on their mental functioning.

- In assessing capacity with vulnerable and self-neglecting individuals like Keith it is important to consider executive function. Repeated refusals of care should raise questions about the ability to execute decisions. The draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function and to consider repeated failed decisions when assessing capacity.

- Ultimately, there does appear to be a lack of confidence in using the Mental Capacity Act with professionals passing the assessment to other agencies. Far more consideration could have been given to how the Mental Capacity Act was used with Keith. Indeed, ultimately, consideration could have been given to building a case for action under e.g. Article 2 of the Human Rights Act 1998.

Again the lack of a clear multi-agency framework and clear leadership around Keith's care would have further hindered the use of the Mental Capacity Act. Within a multi-agency meeting, professionals could have considered his mental capacity from a

number of angles and have professionally challenged situations in which they felt that the approach was inappropriate.

The *Carers Thematic Review* recommended that: *"Manchester Safeguarding Partnership should consider hosting a practice workshop to enable practitioners to explore how to balance professional judgements about choice and control with protection, in cases of adults with capacity who self-neglect."* It is unclear whether this event was held but Keith's care suggests that such training is an ongoing requirement.

Keith had an apparent pattern of excessive alcohol use. It is likely that this had a significant impact on his life and on the health problems that led to his death. What is also clear is that Keith was resistant to engaging with help on his alcohol use disorder. As such he falls into the category of "change resistant dependent drinkers" described in Alcohol Change UK's *Blue Light* manual. Practitioners commented that local specialist Alcohol Services do not work very well for this group. They are described as requiring clients to be motivated to address their drinking and ready to self-refer.

This review has already highlighted the importance of assertive outreach approaches. Having assertive outreach capacity in the local specialist Alcohol Services would have provided an option which would appear to have been well-designed for Keith. This reflects Finding 7 of the *Self-Neglect Thematic Review* which argues that the provision of services for those with alcohol dependency needs to be commissioned in such a way as to provide service users with continuity and flexibility and be part of a care pathway with a strong outreach ethos.

A separate Specialist Substance Misuse Social Work team is based in the City Council; this could have been appropriate for Keith and it is surprising that this referral route was not pursued.

Beyond enhanced services Keith's alcohol use highlights a need for accurate assessment and recording of alcohol consumption and associated harm. At the very least, Keith's care is a reminder of the importance of robust alcohol screening processes to ensure that any alcohol-related risk is identified and highlighted. In accordance with NICE Public Health Guidance 24, professionals working with the public need to be alert to the possibility of alcohol use disorders and should be routinely asking the AUDIT screening tool questions and using professional curiosity to explore this issue.

Keith was a regular smoker and had COPD at his death. This is a sub-theme in this SAR but it is reminder that agencies should be considering the impact of smoking from two perspectives:

- the heightened risk of accidental fire and fire death in people with alcohol problems who are also smoking; &
- the prevalence of smoking and its specific impact on the health of people with alcohol problems.

20. Good practice

Many agencies made efforts to help Keith. There is no sense that he suffered from professional neglect or prejudicial attitudes. Practitioners appear to have tried to help him within the framework of their particular discipline. In particular the relationship between the Carers and Keith appears to have been very positive despite the challenges he presented.

Manchester City Council's Statutory Substance Misuse Team should be recognised as a model of good practice in the national context – it is sad that Keith was not referred to the service.

The referral of Keith to the Fire Service for a home safety check is a model of good practice.

21. Recommendations

Recommendation A

MSP should review the existing policy for escalating difficult to engage individuals and the Managing Risk Together Protocol to reassure itself of their effectiveness. Messages about the importance of escalating those at high risk of harm to multi-agency agency management frameworks needs to be cascaded as widely as possible through multi-agency training and agencies own communication systems.

Recommendation B

MSP should consolidate existing learning and resources in the system that guide professionals on how to respond to individuals requiring safeguarding but whom agencies find difficult to engage and develop a brief document that guides practitioners in relation to this area of practice. (This guide could equally apply to vulnerable clients outside of the safeguarding context).

Recommendation C

MSP should ensure that there is ongoing training and messaging about the need to raise safeguarding concerns about vulnerable individuals and that, within all health and care agencies, practitioners are:

- confident in the recognition of self-neglect as a form of abuse under the Care Act (2014)
- able to identify self-neglect concerns through effective triage and recognise when those concerns require a safeguarding enquiry under s42(2)
- familiar with the need for multi-agency meetings to share information and risk
- providing feedback to referrers on the reasons why a referral is not viewed as appropriate for safeguarding, in order to support professional development
- ensuring that, if the s42 criteria are not met, systems are in place to address significant presenting needs or risks.

Recommendation D

MSP should ensure that guidance and training is available to support professionals to consider the use of the Mental Capacity Act in the context of clients that agencies find difficult to engage. This should include reminders about the importance of considering executive capacity and that people with capacity may still need ongoing help with their decision-making, for example, advocacy.

Recommendation E

Substance misuse service commissioners should review whether the specific needs and impacts of chronic, change resistant and dependent drinkers are:

- identified in strategic needs assessments
- and addressed in any future commissioning plans.

In particular, this may require further investment in assertive outreach capacity for this group of clients.

Recommendation F

MSP should share the content of this review with Manchester City Council's Public Health Team and ask them to ensure that all frontline services are aware of, and are using, robust alcohol and drug screening tools such as the AUDIT tool to identify and record the level of substance related risk for clients.

Recommendation G

MSP, and its various partner agencies individually, should ensure that frontline staff are reminded of the importance of the inter-connected issues of smoking risk and fire risk with vulnerable clients.

Appendix 1 – Key lines of enquiry for Keith SAR

- Should local agencies have appointed a care coordinator / lead person to drive and oversee his care? Who should that person have been (post not name)?
- Would Keith have benefited from an outreach / engagement focused worker?
- Is there a need to improve the use of multi-agency meetings?
- Are there pathways for escalating these cases?
- Does this case suggest professional development needs around assessing under the MCA?
- Has the MCA been used appropriately in this case?
- Did a focus on mental capacity impede the provision of care?
- Should greater efforts have been made to assess and address his alcohol use?
- Is there a need for clear policies and procedures for working with difficult to engage clients?
- Was the impact of trauma on Keith adequately addressed?
- Was the impact of cognitive impairment sufficiently considered in judgements about his needs and capacity?
- Was the safeguarding process correctly followed?
- Was his risk of exploitation by others adequately understood?
- To what extent did Covid-19 impact on Keith's care?
- Was there good practice that agencies would like to highlight?

Appendix 2 – Injuries noted on Keith's body post-mortem

1. On his right hand - bruising on the upper side of his hand from knuckles to the base of his wrist - purpled
2. Cannula present in right forearm
3. Mark consistent with needle mark on crook of right elbow
4. I inspected the head and around the ears to find no marks or signs of injury
5. White circular mark on left shoulder
6. Bruise on inner left forearm
7. Abrasion just below right pelvis , just below bone area with two circular marks next to it
8. Red spotted marks on bone area of pelvis
9. Linear marks across his right lower side parallel with his ribs - these were reddened
10. Light reddening to lower part of back - consistent with death where blood pools in the lowest parts of the body
11. 3 x 5.5cm pressure sore on right shoulder blade
12. Squared (with one side missing) mark on back on right side just below right arm pit
13. Linear mark on right back shoulder area around 5cm long
14. Left pelvis pressure sore noted
15. Lower left pelvis area - pressure sore consistent injury noted
16. Left knee on rear small bruise noted on the outside of his knee area
17. There was reddening on his left knee at the rear
18. There was a small red mark on the bone area on the left ankle
19. His feet were brown in colour and the nail on his large toe had browned and was long and curved