Safeguarding Adults Review:

Adult Q

Overview Report

Confidentiality statement

This report is strictly confidential and must not be disclosed to third parties without discussion and agreement with the Chair of the Bracknell Forest Safeguarding Board.

The disclosure of information (beyond that which is agreed) will be considered a breach of the subject's confidentiality and a breach of the confidentiality of the Agencies involved.

Independent Report Author: Mark Dalton

Date: March 2024

Contents

Pen Picture of Adult Q

1. *Adult Q had a funny and witty personality despite her challenging upbringing and poor mental health. Adult Q loved to spend her free time gaming and listening to music such as the Backstreet Boys. Adult Q was a loving and fun mother who enjoyed not only spending time with her family but also with her close group of friends. In the past she loved to go on holidays with her friends, when she was there, however, due to her low self-esteem and confidence levels it took a lot of persuasion for her to go.*

2. *Adult Q had quite an addictive personality however she never had a bad or negative relationship with alcohol until she experienced a sexually traumatic event in which she then turned to alcohol to suppress her emotions surrounding the event. After this, Adult Q's way of coping with other traumatic events such as her mother's death in July last year and the deterioration of her long-term relationship was to drink alcohol to suppress her emotions.*

3. *Throughout Adult Q's life, she had several different jobs and served many different roles within society, however, her most recent job at a local school in Bracknell was her favourite as she was an LSA working on a one-to-one basis with children with additional needs. I feel that Adult Q had found her passion within this job, and it gave her a purpose and lifted her mood and overall well-being. Adult Q was almost a different person, she loved working in the school and went from being the lunchtime controller to becoming the LSA and she genuinely enjoyed going to work, she would usually come home from work and be so eager to tell her kids all about her day. Unfortunately, Adult Q lost this job during COVID, which as well as dealing with the emotional struggles of lockdown had a knock-on effect on her mental and emotional well-being.*

4. Adult Q's cousin wrote this pen picture on behalf of her daughters. It is part of a family statement prepared for the Coroner's Inquest on 28th June 2023.

Introduction.

5. On 8th March 2023, Adult Q was found dead at home by her adult daughter and another relative who had been trying to support her in the preceding months. She was alone in the house and she had likely died 24/48 hours before she was found.

6. Adult Q's death was not unexpected; she had made serious attempts to take her own life by overdosing on alcohol and prescription tablets on 8 occasions in the previous 24 months.

7. Those who knew Adult Q believe that these were serious attempts to end her life and they were increasing in both severity and frequency in the months before she died. During the eight months before her death, significant life-changing events occurred, and it appears that these events affected her motivation to live and her ability to control her alcohol consumption. These events included the death of her mother, who played an integral part in supporting Adult Q, and the ending of a long-term relationship. These events increased Adult Q's isolation and she became progressively cut off from friends and family.

8. In hindsight, there is an inevitability about Adult Q's death. Despite the best intentions of professionals and relatives she resisted offers of help and was unable to control her drinking alone. Her problems were well known to the local hospital and community alcohol services and to a lesser extent, the Police and Social Care.

The decision to undertake a Review.

9. Under the requirements of Section 44 of the Care Act 2014, there is a duty on Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) where it is known that an adult in its area with care and support needs has died, or they are still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

10. To establish the facts, a Rapid Review was undertaken to establish whether any agencies had prior knowledge of Adult Q. The Rapid Review process was initiated on 11th May 2023 and the results of the agency responses were considered by the Rapid Review (RR) panel of the Bracknell Forest Safeguarding Board on 31st May 2023.

11. The RR panel agreed that Adult Q's death met the criteria for undertaking a safeguarding adult review in that:

    i. "An adult in the area has died as a result of abuse and neglect (whether known or suspected) and there is concern that partner agencies could have worked more effectively together."

12. Mark Dalton was appointed to undertake the review on behalf of the Bracknell Forest Safeguarding Board on 26th June 2023. He is an independent social worker with experience in undertaking reviews on behalf of Safeguarding Boards and Community Safety Partnerships.

13. The first Panel Meeting took place on the 24th July 2023, where the scope of the review and terms of reference were established. It was agreed that independent management reviews (IMRs) would be commissioned from the following agencies:

i. Thames Valley Police.
ii. New Hope DAAT (Drug and Alcohol Action Team)
iii. Mental Health Services to include: BHFT CMHT/BFC Mental Health, Frimley Health Foundation Trust/Surrey & Borders Partnership Foundation Trust
iv. Bracknell Forest Childrens Social Care
v. Bracknell Forest Adult Social Care
vi. NHS Frimley ICB
vii. Berkshire Health Care Foundation Trust (BHFT)
viii. Berkshire Community Mental Health Team (CMHT)
ix. South Central Ambulance Service NHS Foundation Trust
x. NSPCC

The overview report author would also contact Adult Q's last employer and the school her youngest daughter attended as part of this review.

The panel agreed that family members would be invited to contribute to the review and would be kept informed of progress. The overview report author met with Adult Q's cousin and her older daughter and discussed aspects of Adult Q's life and the findings of this review.

Terms of reference

14. See Appendix 1 for the full Terms of Reference.

15. The timeframe for this review is from 1st January 2020 - which is approximately the time her drinking became a problem, until the 8th March 2023 - the day Adult Q was found deceased.

Parallel processes

16. There are no ongoing investigations or enquiries following Adult Q's death. A coroner's inquest was concluded on the 28th June 2023. The medical cause of death was acute alcohol toxicity. The narrative verdict noted that Adult Q had suffered for many years from dependency on alcohol.

Background information

17. Adult Q was part of a large family and had many relatives who live locally. She was witness to domestic abuse between her parents when she was a child, a relative remembers Adult Q and her brother frequently coming to stay with them when there were problems at home.

18. Adult Q's older brother sadly died of a drug overdose in 2007.

19. Adult Q had 2 children, although the relationship with the children's father ended whilst the eldest daughter was still a toddler. The relationship continued on and on/off basis for several years. As a single parent, Adult Q relied heavily on her mother for support. At times, this relationship was difficult and both parties became frustrated with each other. Nonetheless, apart from the bond with her children, this was the most important relationship in Adult Q's adult life.

20. Adult Q's family recalls that she always had problems with her mental health from her adolescence onwards. Although there was no formal diagnosis they have numerous examples of behaviour which is indicative of a bipolar disorder. They have described bursts of chaotic and frenetic activity followed by 2 or 3 days of depression when Adult Q would not speak to anyone in the household.

21. At the time of Adult Q's death her older daughter was a young adult, living independently with her partner whilst her youngest child was in secondary school. Her youngest daughter lived with her father and her older sister but would visit Adult Q.

22. Adult Q's problems with alcohol seemingly developed over the last 3 to 4 years. Relatives have suggested that a serious sexual assault in the autumn of 2020 (which was not reported to the Police at the time) by a person who was known to Adult Q and continued to have contact with her was a significant trigger event.

23. Adult Q's last relationship ended in April 2022. She lived with a partner who had significant mental health issues. She would sometimes describe herself as his carer, although this was not a formally recognised caring arrangement. The

relationship ended in the spring of 2022 after Adult Q made allegations of domestic abuse against him. This relationship is significant for several reasons; firstly, his presence was thought to be a protective factor in the context of caring for Adult Q's youngest daughter when she visited the home. Secondly, ending this relationship left Adult Q more isolated and correspondingly more dependent on her mother.

Chronology of significant events

24. The following chronology of significant events has been compiled from agency records and conversations with family members. In-patient events are highlighted in blue and for the most part, follow the discovery of attempts by Adult Q to end her own life. The records show that these attempts were becoming more frequent and the quantities of alcohol and tablets increased in the latter half of 2022.

25. Family members have also helped provide some context to these events and their insights have been included in the following narrative.

Significant events

26. **February 2020.** Adult Q reported to her GP that her partner was suffering from severe mental illness with psychotic episodes and that she was his carer. She requested time off work for this. Further entries report her partner's psychosis in May and October 2021. This is significant because other agencies recorded her partner as a protective factor supporting Adult Q and safeguarding her younger daughter (who was also registered with the practice). Her partner was not registered with this practice and therefore the GP could not access his record and verify his diagnosis.

27. It is also recorded on her GP notes that she attended the local General Hospital with suspected gallbladder disease in February 2020 and was discharged with Tramadol for pain management. Adult Q was prescribed Tramadol for pain management between 2018 - 2021. The last prescription issued for tramadol was on 19th January 2021 for sixty 50mg capsules. Adult Q was routinely asked about her mental health and any suicidal ideation or plans in consultations with her GP. This is standard practice. It is not clear what the depth of this exploration was with Adult Q, given her history of suicide attempts.

28. **6th October 2020.** The NSPCC Childline Helpline received an anonymous referral expressing concern for Adult Q's younger daughter. The caller alleged that the daughter lived with Adult Q and they believed that Adult Q was an alcoholic who drank daily. The caller did not consider there was a risk of physical harm, but emotional abuse and neglect. The caller stated they had

last seen the daughter on 26th September and spoken to her on 5th October. The NSPCC referred the call to Bracknell Forest Children Services on 7th October 2020. This was investigated by Children's Social Care who established that the daughter in question was living with her older sister at the time. Lateral checks were made with the school and her father which confirmed that she was safe.

29. **16th October 2020.** Children's Social Care received a referral from Adult Q's employer, a local primary school. Adult Q had been employed as a lunchtime supervisor since November 2016. Adult Q had disclosed to a colleague at the school that she had been the victim of sexual assault and she shared some information about what had happened.

30. Adult Q was clearly upset and the school Business Manager started to provide regular support and guidance. An arrangement was made that Adult Q would check in every day just to say she was okay. The Business Manager and one of the mental health staff also provided information about Helplines and offered to contact them with Adult Q. Adult Q told the mental health worker in the school that she felt safe because the alleged abuser knew he had done wrong and she reported eating and sleeping well.

31. The school made a safeguarding referral on the 16th October but noted that Adult Q never mentioned any impact on her daughter i.e. where she was when the assault took place or whether she was affected by it. Also, she never spoke of any threats to her daughter – unlike the accounts she gave later to hospital staff.

32. On one occasion the school were concerned about Adult Q's presentation and believed she was under the influence of drugs or alcohol and was trying to hide this by entering the school through a different entrance and avoiding the member of staff she normally spoke to.

33. To emphasise to Adult Q the need to comply with the arrangements that had been put in place a meeting with senior staff and the HR representatives from the Academy Trust took place. The main issue for the school was the deception and avoiding the daily check-in. Adult Q's behaviour would not have led to an automatic dismissal. After the meeting, Adult Q thought things over for a few days and submitted her resignation.

34. **22nd October 2020.** As a result of the referral to Children's Social Care, a practitioner from the MASH[1] (Multi Agency Safeguarding Hub) made 3 unsuccessful attempts to contact Adult Q, and a decision was then made to step down to Early Help.

35. It should be noted that the information contained in Children's Social Care records is more concerning than the way the situation is described above. Children's Services recorded the information from the school as stating that Adult Q was "not being fit to work and especially around children." Later there is another statement that "Adult Q will be sent off-site as she is not safe to be working with children." Given this information, the correct course of action would have been for the school to contact the LADO[2] within 24 hours of the concern being known. The LADO would then have provided a safeguarding consultation to the school.

36. **22nd October 2020.** The manager at the MASH directed the social worker to contact the school and advise them to contact the LADO. This was the accepted procedure where there were concerns about a person employed in a position of trust. By this time Adult Q had resigned from her job at the primary school.

37. **28th/29th October 2020.** A practitioner from the MASH team made 3 further unsuccessful attempts to contact Adult Q by phone, text and email, a decision was then made to step down to Early Help. It should be remembered that Covid restrictions were still in place and practitioners would have been aware that the second government lockdown was due to be announced on 31st October.

38. Early Help practitioners emailed the Head of Pastoral Care at the school Adult Q's youngest daughter attended, to check contact details for Adult Q and also to ask them to keep an eye on her daughter and if they noted any support needs that Early Help could provide. The contact with the school occurred over half term which may explain why there was no response. Because they could not obtain any consent from Adult Q, Early Help had no option but to close their referral.

39. **31st January 2022.** Adult Q's partner contacted the NHS 111 service because she had taken an overdose of tramadol tablets. A telephone

[1] The Multi-Agency Safeguarding Hub (MASH) is a system for organising the response to safeguarding concerns. The Bracknell Forest MASH is the single point of contact for all safeguarding concerns about children and young people living in Bracknell.
[2] The Local Authority Designated Officer (LADO) - advises agencies who work with children on the management of allegations against staff. Allegations Against Staff or Volunteers who Work with Children

assessment was conducted and Adult Q was referred to the Hospital Assessment Centre for a face-to-face assessment.

40. Adult Q self-referred to Hospital following this consultation with the NHS 111 service. It is recorded that she had a history of suicidal thoughts, stating she would do it again and that she had drunk 6 bottles of wine the day before and drank two bottles every day.

41. Adult Q told the hospital that she lives in a house where she was raped a year and a half ago by a known person who would harm her family and her 14-year-old child if she reported it.

42. She stated she could not move, as she cared for her mother. The hospital considered making a safeguarding referral and contacting the Police. However, Adult Q would not consent to this and because she was assessed as having mental capacity a referral was not made.

43. **1st February 2022.** Following Adult Q's hospital admission on 31st January she had a telephone consultation with her GP where she denied further suicidal ideation and described her partner as supportive. It is concerning that her partner is described as both supportive and also as suffering psychotic episodes and requiring her to care for him. It seems improbable that both could be true at the same time.

44. **3rd February 2022** Adult Q was referred to the Common Point of Entry (CPE)[3] by the Psychological Medical Service at the local Hospital following this overdose and sent the requisite opt-in letter. Three follow-up letters were sent but no response was received by the deadline of 11th February and the referral was discharged on 22nd February.

45. **8th February 2022.** Adult Q's partner called the Police and told them he was concerned that she was an alcoholic and had attempted to take her own life with tablets a week and a half previously. The Police advised Adult Q's partner to seek medical attention in the first instance. They assessed that there was no role for the Police because there was no active attempt to commit suicide. They advised Adult Q's partner to seek help from Adult Social Care.

46. The incident was reported by the Police to Adult Social Care who reviewed the information on 16th February and requested further information because there was insufficient detail to make a referral decision. An Adult Protection

[3] Common Point of Entry (CPE) is now called the Gateway and is the referral pathway for community mental health services.

Vulnerability Assessment[4] was completed by the Police and assessed as a B-grade incident (risk of harm but not imminent) without any further contact with Adult Q. The assessment also recorded the non-recent rape offence as a possible trigger for her mental health and alcohol abuse. Subsequently, a referral was made to the Community Mental Health Team.

47. **28th March 2022.** Adult Q's partner contacted the Crisis Resolution Home Treatment Team (CRHTT) and reported concern regarding her escalating alcohol use. He was advised to contact the Common Point of Entry (CPE) and New Hope (Drug and Alcohol Action Team), but without Adult Q's consent, the services were not able to provide any support.

48. On the same day, the Police received a third-party report that Adult Q was being assaulted by her partner. The report also stated that he had hit Adult Q in the past leaving bruises. The Police attended and Adult Q disclosed that she had bruises caused by her partner 2 weeks previously. She declined to complete a statement and also changed her mind about completing a domestic abuse risk assessment. Unfortunately, the Police were unable to complete a risk assessment at the time, and on reflection have suggested that the delay and change of officer from the one who first attended may have inhibited Adult Q from agreeing to the assessment at a later date. However, due to resourcing issues, their priority was to convey her partner to the Police station following his arrest.

49. The domestic abuse incident was investigated by the Police, but Adult Q declined to support the investigation and consequently, the investigation was filed on 14th April 2022 (an evidence-led prosecution was considered, but legal advice was Adult Q's reluctance to support the investigation created evidential difficulties which would have precluded a successful prosecution).

50. This incident precipitated the ending of a relationship between Adult Q and her partner. He would subsequently claim that Adult Q had hit him several months previously but had no evidence of injury and was unable to say exactly what had happened.

[4] The ABCDE model was devised as an assessment tool purely for mental health issues. It is used by Thames Valley police to assess a range of vulnerability.
The tool consists of 5 areas:
Appearance – what you see including physical indicators of vulnerability.
Behaviour – how the individual presents and if this is in keeping with the situation.
Communication – what the individual is saying and how they say it.
Danger – whether the individual is in danger and whether their actions put themselves or others in danger.
Environment – where they are situated and whether anyone else is there.

51. **31st July 2022.** Adult Q's mother died, within 3 weeks of a diagnosis of terminal cancer. Friends say that she had been ill and complaining of pain for some time but had avoided going to the doctor. When she did eventually go the diagnosis was terminal and her death was an enormous shock to friends and family alike.

52. Adult Q had lost her primary source of emotional and financial support and her family was concerned about how she would cope without her mother.

53. **2nd August 2022.** A relative contacted the Police because they could see Adult Q lying on the floor but were unable to get into her property. The Police forced entry, Adult Q was found alive but initially unconscious and heavily intoxicated. She was found naked under a blanket and had wet and soiled the bed and sofa. The house was described as very dirty and messy. It was noted within the ABCDE assessment[5] under the heading of 'danger' that 'Adult Q will continue drinking to the point she hurts or kills herself.'

54. Adult Q was taken to Hospital by ambulance. No safeguarding referrals were made on this occasion.

55. Hospital records record that she was found unconscious with three empty bottles of gin and an empty wine bottle plus a half-empty packet of tramadol. She had bruises and scratches on her face. Notes state she had not been taking her prescribed antidepressants lately. Hospital records noted that she had been alcohol dependent for 18 months, (although in reality it was 3 years).

56. Adult Q's suicidal ideation and attempt to end her own life at this point may have been the culmination of the sudden and unexpected death of her mother, the breakdown of the relationship with her partner and the other unresolved issues she has lived with for some time; domestic abuse (including violence between her parents she had witnessed growing up) the alleged sexual assault and alleged ongoing threat to her daughter from her abuser and finance and housing problems. Adult Q was assessed as a high risk of suicide.

57. Professionals consulted with Adult Q's eldest daughter, to understand further her mother's history and current situation. Her daughter confirmed her mother had had a problem with alcohol for three years and had been referred to the psychiatric liaison team at the hospital. Professionals discussed their safeguarding concerns with Adult Q and offered her the opportunity to meet with a member of the hospital safeguarding team to support her in understanding their concerns.

[5] See footnote 3.

58. The hospital made a Children's Safeguarding Referral on 5th August 2022 about her teenage daughter who was living with Adult Q's eldest daughter. Adult safeguarding was considered and discussed with Adult Q explaining it was to help "protect her" but she did not want a safeguarding referral and records state "no further action for adult safeguarding."

59. **9th September 2022.** Adult Q called the Police and told them that she wanted to end her life. She said that she had taken 20 pills and was trying to harm herself. The Police transferred the call to the Ambulance Service.

60. On arrival, the ambulance crew were unable to raise Adult Q by knocking on the door but found it unlocked and entered the property. Adult Q appeared distressed and smelt of alcohol and she was conveyed to Hospital. On this occasion, the ambulance crew also submitted a safeguarding referral.

61. **10th September 2022.** Adult Q was seen in the emergency department of Royal Berkshire Hospital by the Psychological Medical Service (PMS) following a reported overdose of tramadol and alcohol. She was assessed as not needing inpatient treatment on this occasion. Adult Q agreed to refer herself to New Hope (Drug and Alcohol Action Team).

62. **15th September 2022.** A telephone call was received by the Crisis Resolution and Home Treatment Team (CRHTT) from Adult Q's cousin requesting advice as Adult Q was intoxicated. It is documented that the phone was on speaker phone and Adult Q declined further support.

63. **1st October 2022.** Adult Q's older daughter called an ambulance because she was concerned that Adult Q was intoxicated and had taken an overdose earlier in the day. When the ambulance crew arrived, Adult Q refused to allow them in the home stating that she had had too much to drink but was now well and did not want any assessment or treatment. The crew believed that Adult Q had mental capacity and she was not taken to hospital.

64. **6th October 2022.** One of Adult Q's relatives contacted the Police because they were concerned she was having a breakdown due to her alcoholism. Adult Q had told her relative that there was an unknown person at her address and she was upset about it. When the Police attended and gained entry they found Adult Q slumped on the floor, she had soiled herself and seemed to be drunk and had possibly also taken tablets. Adult Q appeared delirious and there was no sign of anyone else at the address.

65. An ambulance crew attended but Adult Q refused to complete an assessment with them. They recorded that she may have taken half a box of tramadol and 2/3 bottles of alcohol and planned to take her own life.

66. An Adult Protection vulnerability assessment was completed by the Police and assessed as a B-grade incident (risk of harm, but not imminent) as the immediate risk of harm was in hand. This was sent to the Adult Social Care who reviewed it and shared it with the Community Mental Health Team.

67. Adult Q was eventually admitted to the Hospital by ambulance. The admission notes record the same issues that had been recorded in August; namely suicidal intent, the rape allegation, bereavement, domestic abuse and the breakdown of Adult Q's relationship. The Ward was aware of Adult Q's history of overdosing on alcohol and prescription tablets.

68. The Ward considered breaching Adult Q's confidentiality and referring her to the Police (because of the rape allegation) but decided against this course of action because they assessed she had the mental capacity and had exercised her right to decline the offer. The issue of consent where there are safeguarding concerns is discussed below.

69. There was further liaison with Adult Q's oldest daughter who reported a deterioration in her mother's condition and her worry that her mother would end her own life.

70. The hospital records indicate that a children's safeguarding referral was made on the 10th of October 2022. This referral was considered by the MASH which concluded that the situation had not changed since the previous referral in August namely that Adult Q's youngest daughter was protected from the consequences of her mother's drinking and overdosing because she lived with either her older sister or her father and she did not visit Adult Q unsupervised. Adult Q declined a referral to the Police or domestic abuse services and refused to engage with community alcohol or mental health services.

71. **30th October 2022.** Adult Q's older daughter contacted the Police because Adult Q was drunk and expressing suicidal thoughts. Adult Q's daughter felt that the Police arriving unannounced would distress her mother and requested they wait until she was present. An ambulance was also dispatched. The ambulance crew found Adult Q awake and alert. She had recently been discharged from hospital on the 10th October 2022. Adult Q told the ambulance crew she had remained sober for a week but had then relapsed.

72. Adult Q was again transported to Hospital; a safeguarding referral was not considered by the ambulance crew on this occasion. Given the previous concerns. a safeguarding referral at this point may have highlighted ongoing concerns that the situation was inexorably deteriorating.

73. This admission was only 24 days after her previous overdose. Adult Q was referred to psychiatric liaison whilst an inpatient and the crisis team on discharge. Hospital notes record the evidence of self-neglect and notes that detoxification had been carried out 4 times in a year.

74. Adult Q discharged herself from hospital on the 4th November 2022 and refused the referral to the Psychiatric Liaison Service. She was re-referred to the Crisis Resolution and Home Treatment Team following this overdose. Telephone contact was made with Adult Q who advised that she was staying with her daughter and follow-up contact was agreed for 7th November.

75. Two telephone contacts and an unannounced home visit were attempted on 7th November; all were unsuccessful. Telephone contact was made with Adult Q's daughter later that evening and a home visit was agreed for the following day. The home visit took place as agreed on 8th November; however, Adult Q had purchased alcohol that morning and therefore a further appointment was agreed with Adult Q for 9th November.

76. Adult Q telephoned the Crisis Resolution and Home Treatment Team (CRHTT) on 9th November and cancelled the planned appointment. An unannounced home visit was completed on 10th November; Adult Q declined further intervention as she was unsure what it would entail. An explanation was provided of what support would look like. However, Adult Q did not agree to engage.

77. Adult Q was discharged from CRHTT on 10th November as she did not feel ready to accept support at that time. This decision was endorsed by the Service Manager, as they had exhausted all the available options for voluntary involvement. The assessment was that although the risk remained moderate and ongoing, Adult Q denied feeling suicidal and was not deemed to be in a crisis that would warrant CRHTT arranging for a Mental Health Act assessment for Adult Q. Information to enable Adult Q to refer herself to community services was provided.

78. The use of the Multiagency Risk Framework[6] could have been considered at this point. There was evidence of a high risk to Adult Q from repeated overdoses, and excessive alcohol consumption. The repeated failure to

[6] Multi-Agency Risk framework

engage Adult Q in any services could have been reason enough to convene a risk management meeting.

79. **16th November 2022.** The CRHTT received telephone contact from Adult Q's eldest daughter. The practitioner was unavailable and return telephone contact was made by the practitioner later that day but was unsuccessful. A further telephone contact from this daughter was received on 23rd November, records show that the call was transferred to CRHTT. There is no record of the daughter's concerns or whether this call was returned.

80. **4th December 2022.** An ambulance was called by Adult Q's older daughter who reported that Adult Q had been on the floor for 2 days and had drunk 24 bottles of wine in that time. The ambulance crew found her partially clothed on the floor covered by towels and a duvet cover. As a result of lying on the floor in the same position, she had also developed pressure sores. Adult Q was taken to Hospital and a safeguarding referral was submitted by the ambulance crew on 5th December.

81. She had taken an overdose of alcohol and tramadol. Adult Q had been on the floor for 2 days and unable to get up before her daughter discovered her. The hospital recorded the evidence of self-neglect.

82. It was noted that Adult Q had previously been referred to community mental health services but had declined to engage with them. She had been discharged from their service because there was no specific mental health diagnosis and she had declined their help.

83. Adult Q was discharged when assessed as fit on the 11th December 2022.

84. The safeguarding referral from the Ambulance Service was sent to the Common Point of Entry which concluded that no action was required from mental health services as the report indicated Adult Q wanted a home transfer and she had agreed to discuss her needs with the housing association and alcohol services. Adult Q's patient records show the report was also sent to the Adult Social Care and Community Mental Health Team (CMHT). A telephone call was made to Adult Q by the CMHT. Adult Q was in Hospital and it was agreed a referral to Adult Social Care was to be made on discharge for support. Adult Q did not consent for the safeguarding concern to progress further as she felt she was able to address her drinking problems given that she had been told she was facing liver damage.

85. **8th December 2022.** The CPE received a copy of a letter from the Psychological Medical Service (PMS) at Hospital to Adult Q's GP stating that Adult Q had been seen in the A&E department following excessive alcohol

consumption, an overdose and being found on the floor hypothermic after a two day lay. Adult Q did not engage with the hospital assessment but had agreed to follow up with support from the CMHT. CPE acted on this letter and accepted it as a referral with a plan to offer a review with their drug and alcohol specialist nurse and to liaise with drug and alcohol services.

86. **14th December 2022.** Adult Q was admitted to Hospital by ambulance. On this occasion, Adult Q was admitted to hospital because of several accidents she had suffered whilst under the influence of alcohol. She had fallen downstairs injured her ankle and burned her arm on an electric heater. Adult Q was assessed as lacking capacity immediately following admission.

87. On 15th December, the drug and alcohol specialist nurse tried unsuccessfully to engage Adult Q in the service. When the Common Point of Entry received a further safeguarding referral from the Ambulance Service report in January 2023 following Adult Q's discharge, they sent her another opt-in letter providing her an opportunity to engage.

88. **15th December 2022.** The Hospital made a referral to the MASH which was passed to Early Help requesting contact with the children's father. The following day Early Help spoke to him and he confirmed that the school were aware of the situation and providing counselling.

89. Adult Q self-discharged after 3 days.

90. **16th December 2022.** The father of Adult Q's younger daughter had telephone contact with Early Help and informed them that her school were aware of Adult Q's circumstances and the death of her grandmother in July. In response to these events, the school were offering his daughter counselling.

91. The safeguarding referral to the MASH was prompted by the safeguarding notification submitted by the Ambulance Service and their concern about home conditions. The patient record at the hospital illustrates the professional uncertainty where there is a lack of clarity about consent from the patient and they are assessed as having mental capacity. This incident was also the first time that the Adult Community Team (ACT) stated they became aware of Adult Q, although no action was taken, and the previous safeguarding referrals from the Ambulance Service had been routinely submitted to Adult Social Care by email.

92. Numerous services, the Community Mental Health Team and the Common Point of Entry (CPE) were aware that Adult Q had declined community services in the past. The CPE documented that they planned to respond to the referral from the Hospital to the effect that Adult Q was not engaged with community

services and an assessment whilst an inpatient would be recommended. There is no evidence this response was sent to the Hospital.

93. The CHMT called Adult Q whilst she was in hospital to check on her well-being. Adult Q agreed for contact numbers to be shared with her via text message for CMHT, the Emergency Duty Team (EDT) and the Crisis Resolution Home Treatment Team (CRHTT).

94. A follow-up telephone contact was arranged for 3rd January 2023 to assess the current situation and possibly arrange a home visit with Adult Q's consent. There are no records to confirm if this telephone contact took place.

95. **12th January 2023.** Adult Q's older daughter called an ambulance as she found her on the floor intoxicated, surrounded by bottles of alcohol and covered in bruises. Adult Q was unable to explain how she got the bruises, but it was evident she was experiencing a lot of falls and her daughter felt she was not safe to live alone. Adult Q was taken to Hospital and a safeguarding referral was submitted by the ambulance crew.

96. Adult Q was admitted to Hospital following a further overdose of tramadol and alcohol with suicidal thoughts.

97. Adult Q was treated for alcohol detoxification and reviewed by alcohol specialist nurses and consultants from gastroenterology/hepatology and psychiatry. Hospital records indicate Adult Q consumed 175.2 units of alcohol per week.[7] It was noted that she had ongoing depression and thoughts of self-harm and suicide with some new hallucinations. She was assessed as being at high risk of suicide.

98. There was increasing evidence of self-neglect; "patient lives in squalor with faeces all over the house, not eating or drinking or cleaning." An adult safeguarding referral was received by Adult Social Care on the 13th January 2023. The referral was forwarded to the MASH (who were aware of Adult Q's younger daughter), New Hope and the Community Mental Health Team.

99. Adult Q also explained there were problems with her boiler and electricity supply at home. Unfortunately, she contracted COVID-19 during her stay in hospital and the electricity company would not enter her home until she was COVID-free.

100. On 17th January 2023, a referral was made to New Hope (Drug and Alcohol Action Team) whilst Adult Q was an inpatient. Adult Q agreed to this

[7] The NHS advise that adults should not drink more than 14 units a week on a regular basis.

contact whilst in Hospital. New Hope's only contact with Adult Q took place on 26th January when she was in hospital. She stated that she remained in hospital and was unsure when she would be discharged. She agreed that she would contact New Hope when she knew when she was going to be discharged. This was the last contact New Hope had with Adult Q. They tried to contact Adult Q on several occasions over the next six weeks and the case was eventually closed on 27th February due to non-engagement.

101. Adult Q was discharged from hospital on 28th January 2023, one month and 8 days before her final fatal overdose.

102. **24th January 2023.** Adult Q was discharged from the Common Point of Entry (now known as Gateway Mental Health Services) as she had not responded to an opt-in letter sent on 12th January. It was considered appropriate to discharge Adult Q from the service at this point as she had not opted into the service and there was no evidence of serious mental illness.

103. **28th February 2023.** A meeting described as a "Pre-Risk Multi-Agency Discussion" was arranged by Bracknell CMHT and attended by New Hope to discuss recent hospital admissions for intoxication and safeguarding concerns raised by the Ambulance Service. It would seem that this meeting was fundamentally the same as a Multi-agency Risk Framework meeting, with the same aims and objectives of sharing information between agencies and finding ways to support Adult Q. Neither Berkshire Healthcare Services CPE, CRHTT, nor the GP were invited to this meeting. The discussion explored the impact bereavement and trauma may have had upon alcohol use and that whilst in hospital Adult Q agreed to community support. Post-discharge she always declined support from services, reporting that she was fine and did not need their help. The referral to New Hope was to be closed due to non-engagement. Consideration was given to support or monitoring from the Community Safety Team or Police Team. Further action from CMHT was to be discussed.

104. **8th March 2023.** Adult Q's older daughter and a cousin entered the house and found Adult Q deceased. The Police and ambulance were called. It was evident that Adult Q had been dead for some time.

Summary

105. Adult Q's death was the culmination of an escalating pattern of suicide attempts. In the last quarter of 2022, they became more frequent and more severe in terms of the amount of alcohol and tablets she consumed. Inevitably, alongside these attempts her physical health and living conditions also

deteriorated to the extent that she began to have other accidents; burns and falls as a result of her drinking problem.

106. Adult Q's family tried on several occasions to raise concerns about the risks she faced. They acknowledged that supporting Adult Q was always going to be difficult, they also believe that agencies were too quick to decide that she could not be helped unless she consented to support. They believed that Adult Q had mental health needs that were undiagnosed and the risks because of the self-neglect were not assessed.

107. An array of community-based therapeutic support was potentially available. These services are available voluntarily and require the patient to opt in to gain support. There is a sound therapeutic principle behind this threshold; in that therapy is more successful with people who have a level of self-motivation.

108. Adult Q's history with services shows that as far as possible she would decline offers of support. A pattern of behaviour was repeated: Adult Q would only agree to engage in treatment when she was an inpatient and agreeing to community support might mean that she was discharged more quickly. Whatever consent she gave was rapidly rescinded or declined when she returned home.

109. Good practice in situations such as this would be to attempt to engage the patient/service user in a discussion around what they wanted to happen when they were intoxicated and incapacitated, so a plan could be made including professionals and members of her family.

110. In hindsight, the best chance of engaging Adult Q in therapeutic support probably occurred when she was employed at the primary school. This was relatively early in her addiction to alcohol; she was supported by people she trusted and with whom she had a positive relationship and who also valued her as a member of the school community. They offered practical help to make referrals on her behalf and support her in making initial contact. Subsequently, all agencies would struggle to achieve this level of engagement with Adult Q.

Analysis

Referral Pathways

111. In reviewing the information provided in this review, it is evident that there is the potential for confusion and delay in the mechanisms used to share information about risk. In Adult Q's case, we have an adult who is presenting

as a suicide risk with alcohol dependency, living in a self-neglecting environment and may also have childcare responsibilities. The records indicate that she also had a history of domestic abuse and sexual abuse and had unresolved bereavement issues. Family members had also raised concerns about undiagnosed mental health problems. Not all of these issues would have been evident at the point of referral (i.e. when the Police or Ambulance Service were called to incidents) but assumptions were made about the actions that would follow after the initial referral.

112. Bracknell Forest is served by Thames Valley Police and South-Central Ambulance Service which are large organisations working across several counties and numerous local authorities. Neighbouring local authorities have different structures and "front doors" for accepting referrals. This is potentially an added complexity for referrers.

113. Bracknell Forest Adult Social Care is comprised of the following teams:

- Adult Community Team – People over 18 with physical disabilities providing a range of support and assistance to individuals facing physical challenges.
- Learning Disability and Autistic Spectrum Team
- Community Mental Health Team - people with severe and complex mental health difficulties. Community Mental Health Team for Older Adults multi-disciplinary Team who following receipt of a referral from a person's GP offers mental health assessments, diagnosis, and ongoing care to help with mental health conditions.

114. Safeguarding referrals arrived into Adult Social Care in different ways but the Adult Community Team (ACT) had inadvertently become a default 'front door.' This team would assess whether the safeguarding criteria were met, identify if the person concerned was already known to the services and if so, allocate to the relevant team. Where the person was not known but the safeguarding criteria were met this would be progressed in line with the Care Act 2014 safeguarding duties by the Adult Community Team. Where the safeguarding issue did not meet the safeguarding criteria there might be a range of actions taken such as offering a Care Act assessment of an individual's needs for care and support and/or a carers needs for support, signposting to an agency or organisation that could support the particular issue or decide that the matter did not require any further action. [8]

[8] Since 02/10/2023 a new model has been implemented introducing a new Adult social care "Front Door" this is known as the 'Adult Social Care Hub'; this has become the initial point of contact for the Corporate Contact Centre, Public and other professionals requiring support from Adult Social Care. The Hub has several functions and includes dealing with all Safeguarding Concerns and

115. This is the process which responded to the safeguarding referrals made by the Ambulance Service. When an adult safeguarding referral is submitted by the Ambulance Service, this is sent from a central hub to an email address in the Adult Community Team. Initial checks are made to see whether the subject is an open case to Social Care. If not the referral is forwarded on to other organisations which may be able to offer help.

116. The lack of assessment, apart from a check to see whether an individual is an open case at this point of referral is the reason Adult Social Care had no record of Adult Q until mid-December 2022 although the first safeguarding referral was made by the Ambulance Service on 9th August 2022. The individual IMRs from the Ambulance Service and Adult Social Care have both recognised there is scope for improvement in how safeguarding referrals are managed. Adult Social Care has also introduced a new Target Operating Model (introduced to Adult Social Care 2nd December 2023) with the aim of greater consistency, oversight and timeliness to the decision-making process for all work coming to the "Front Door" (Adult Social Care Hub).

117. With regard to referrals to Community Mental Health Services, and New Hope (Drug and Alcohol Action Team), although they were informed of some of the safeguarding referrals, these notifications and requests for services were initiated following Adult Q's admission as an inpatient.

Multi-agency risk framework

118. Another option for concerned agencies in Bracknell Forest would have been to consider using the Multi-agency Risk Framework[9]. In 2018 Bracknell Forest Safeguarding Board introduced a Multi-agency Risk Framework to enable any agency which has concerns for a service user where the circumstances sit outside the statutory adult safeguarding framework to convene a multi-agency meeting to bring different professionals together and agree on a joint approach where there are complex needs.

119. The current guidance makes no mention of the involvement of family members and in Adult Q's case it would be important to involve them at an early stage because they played a central role in her care, they were willing to provide support and work along professionals and could help establish the facts of Adult Q's situation.

Enquiries. The aim is for greater consistency, oversight, and timeliness to the decision-making process for all work coming to the "Front Door".

[9] Multi-Agency Risk framework

Alcohol dependency

120. The starting point of any analysis of the events leading to Adult Q's death is recognising that alcohol dependency/addiction is a chronic disease that causes changes in the brain that prevent a person from making rational decisions regarding alcohol use.

121. Relatives have described Adult Q's wider family as one where alcohol was an important part of social gatherings. There are a number of other examples in the family of serious alcohol-related problems including premature death. Adult Q's older brother had also died of a drug overdose some 14 years earlier. None of these factors caused Adult Q's dependency, but everyone with alcohol-related problems is introduced to drinking at some stage and this family culture would have been an avenue to explore with Adult Q in terms of her motivation to drink and the reasons why she wanted to stop.

122. Understanding the reasons Adult Q drank is complex; there are several overlapping social, emotional and psychological issues in addition to the cultural factors suggested above. In Adult Q's case, these included the trauma of the sexual assault she suffered in 2020, the loss of her job (and possible embarrassment in the way she lost it), being the victim of domestic abuse and witnessing it as a child, the ending of her relationship with her partner, losing the care of her youngest child and the unexpected death of her mother. These events inexorably removed the pillars of her self-esteem; the satisfaction she had from a job she loved, describing herself as a carer for her partner and as a parent to her daughter. As a result of the events of 2022, she became progressively isolated and despondent.

123. Adult Q's dependency switched from her mother to her oldest daughter and a cousin. These were people who attempted to keep an eye on her and Adult Q would contact them when she was at her most desperate. Family members are sadly confident that Adult Q sincerely wanted to end her life and there was a high risk of intentional suicide in the 6 months before she died.

124. Adult Q firmly resisted all attempts made to engage her in community-based treatment programmes. She would usually choose the path of least resistance; and be compliant and open to the prospect of support whilst she was in hospital, only to withdraw her consent on discharge.

Consent

125. On numerous occasions Adult Q exercised her right to withhold her consent for information about her to be shared between agencies. It is also documented that she would not give her consent for referrals to be made to community services.

126. Consent becomes a different issue when safeguarding enquiries under section 42 of the Care Act 2014 are made. When there were the initial concerns that the person who sexually abused Adult Q may also pose a risk to her younger daughter, and subsequently, when referrals for self-neglect were made to Adult Social Care, it was not necessary to obtain Adult Q's consent under the provisions of section 47 on the Children Act 1989 and section 42 of the Care Act 2014 for the enquiries to proceed.

127. The statutory guidance states that "the adult should always be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse."[10] However, involving the person in the safeguarding enquiry is different from requiring their consent to undertake the enquiry. The statutory duty is on the local authority which must undertake a safeguarding enquiry when the requirements of section 42 (1) of the Care Act are met.[11]

128. Despite Adult Q not consenting to referrals, four safeguarding referrals were made by the hospital; 2 to Adult Social Care and 2 to Children's Social Care. Arrangements were made for the safeguarding team to talk to Adult Q so she was informed of the rationale and progress of the referrals. This was good practice and in line with the statutory guidance.

129. The issues of consent, in the sense of a person giving "permission" for a statutory obligation can be confusing, particularly in cases where the individual is placed at risk by their own actions. With regard to the safeguarding concerns, Adult Q's consent should not have been the determining factor in whether to make a referral.

The presumption of Mental Capacity

130. It is important to note that the Mental Capacity Act 2005 does not only apply to the individual's physical, emotional or mental welfare, it is based on the protection of the individual's autonomy to make decisions for themselves.

131. The significance of assessing mental capacity in Adult Q's case would have included the consideration of detaining her under the provisions of the Mental Health Act 1983 and admitting her as an inpatient for further detox treatment. It must be said that this would be a highly unusual outcome and unlikely to be supported legally. However, it is a mark of the desperation of Adult Q's family that they felt it was the only option in getting her to comply with treatment.

[10] Care and support statutory guidance. 14.80
[11] Care Act 2014 s42 (1)

132. Except for the final hospital admission in January 2023, Adult Q was always presumed to have mental capacity. The records indicate that this was assessed although they do not contain details of how this decision was arrived at. The issue has been raised that while Adult Q may have demonstrated the capacity to make decisions about her immediate situation, her ability to think through the consequences of her decisions and anticipate difficulties had been adversely affected by sustained alcohol abuse.

133. The process of assessing a person's ability to think through the consequences of their actions requires an assessment of their executive functioning[12] which is extremely difficult to assess based on an interview alone. The repeated overdoses and subsequent detox may have been considered evidence that in Adult Q's case, she was unable to fulfil her plans to stay sober and seek help of her own volition.

134. This created a paradox where Adult Q had mental capacity when she was sober enough for this to be assessed, but the assessment could not consider her state of mind when she had attempted to end her own life.

135. An accurate assessment of Adult Q's mental capacity would have involved 3 components; conversations with her, conversations with people who knew her best and real-world evidence of her behaviour. There was a clear mismatch between what Adult Q said she was able to do to control her drinking and the reality of her situation. It is well known that consuming alcohol to the extent that Adult Q did would impair her executive functioning.[13] A more three-dimensional assessment could also have raised concerns about the problems she faced in addition to alcohol such as the self-neglect and accidents in the home.

Self-neglect

136. Adult Q's self-neglect is evident in all the dealings that agencies had with her. It may be that some agencies such as the Ambulance Service thought that consideration of self-neglect was implied by their safeguarding referrals. However, determining the extent of self-neglect can be complex and implies the existence of a chronic long-standing condition, whereas the Ambulance Services were responding to Adult Q at the point of crisis.

137. Recognition of Adult Q's living conditions and self-care as evidence of self-neglect would have needed involvement from Adult Social Care. If the

[12] This is sometimes referred to as the difference between assessing a person's decision-making capacity when they can seemingly 'talk the talk' (decisional capacity) but cannot 'walk the walk' (executive capacity); especially when the inability to 'walk the walk' may be the result of an impairment or disturbance of the brain – in Adult Q's case this would have been due to alcohol abuse.
[13] How Does Alcohol Affect Brain Function & Behaviour?

correct procedure had been followed this would have led to a Multi-Agency discussion and involvement with her family which would have been another avenue to explore in terms of recognising her predicament and getting her engaged in services.

138. Berkshire Adults Safeguarding Policies and Procedures include a procedure for working with cases of self-neglect.[14] The policy lists most of the behaviours that Adult Q was known to exhibit as possible evidence of self-neglect including:

i. Substance misuse,
ii. Being unable or unwilling to provide adequate care for self.
iii. Malnutrition or dehydration; little or no fresh food in the fridge or food that is off or out of date.
iv. Living in 'squalid' conditions and lack of functioning utilities
v. Neglecting household maintenance creating hazards or fire risk
vi. Untreated or improperly attended medical condition, non-compliance with required health or care services, inability or unwillingness to take medication or treat illness or injury.
vii. Coming into repeated contact with services as a result of seemingly capacitated but high-risk decision-making and risk-taking.

139. If Adult Q's behaviour had been recognised as self-neglect at any point in the last quarter of 2022 it would have provided the opportunity to convene a meeting under the Multi-Agency Risk Management Framework.[15]

140. The benefits of convening a meeting would have been the opportunity to pool information and share recognition of the nature and extent of the risks posed by Adult Q's self-neglect. It would also have clarified the issue of where her children were living, and whether they were safe. It would also have recognised the caring role played by Adult Q's older daughter and cousin and enlisted them as partners in creating a safer environment for Adult Q to live in.

Domestic abuse

141. The impact of the domestic abuse Adult Q had suffered was never assessed while she was alive. It is known that she witnessed serious domestic abuse as a child between her parents and on several occasions was taken out of violent situations along with her brother for their safety. As an adult, she reported a serious sexual assault to her employer in November 2020. An

[14] Self-Neglect Policy This has recently been revised and the new version will be published on the Boards website.
[15] Multi-Agency Risk Framework

incident that many of those close to her attribute to the escalation of her problems with alcohol. A further incident of domestic abuse from a different partner was reported in March 2022.

142. As an adult victim, Adult Q expressed embarrassment and a reluctance to engage in services for victims of domestic abuse. In the case of the sexual assault, she also said that she may have been partly responsible. Self-blame is common in victims of domestic abuse for a variety of reasons; in Adult Q's case, the abuse she witnessed as a child may have been traumatising and was never addressed. With regard to the abuse she experienced as an adult, the presence of alcohol would enable the abuser to shift the blame or provide a rationale for the abuse.

143. Adult Q's circumstances illustrate how complex and interrelated the issues that affect whether a person is ready to acknowledge the reality of the abuse in their relationship and has the strength and confidence to reach out for support.

Adult Safeguarding Issues

144. An ambulance was called out to Adult Q on seven occasions, on four of those occasions ambulance crews had made safeguarding notifications. These notifications are intended to highlight concerns for the hospital and contribute to treatment and discharge plans. They would also send a referral to Adult Social Care which in turn would send a notification to other community services. This process did not practically affect any service that was offered to Adult Q. The most it seems to have achieved is sharing information about further incidents, however, as Adult Q was not an open referral to any agency these notifications were only logged.

145. Of the four occasions when the ambulance crews highlighted safeguarding concerns, three were occasions where there was very evident physical injury. Issues of self-neglect were not considered. While the attending ambulance crew would not have knowledge of a patient over time, some of Adult Q's presentations were suggestive of self-neglect and it would have been helpful for the ambulance crews to include their observations about this.

146. There were three occasions when no safeguarding notification was made; on one of those occasions Adult Q declined to go with the ambulance crew and was not taken to hospital. However, the other two incidents are strikingly similar to the ones where a safeguarding notification was completed. To some degree, individual professional judgment will affect decision-making, which is where reference to the self-neglect policy would be relevant.

147. It may have been expected that after four notifications in a relatively short period, a Multi-Agency risk assessment could have been initiated. But apart from a series of notifications between agencies, no action was taken.

148. The only Multi-Agency meeting occurred on 28th January 2023. This meeting was arranged by the Community Mental Health Team (under the framework of Social Care as opposed to Berkshire Healthcare services) and attended by New Hope to discuss recent hospital admissions for intoxication and safeguarding concerns by the Ambulance Service. Berkshire Healthcare Services CPE and CRHTT[16] were not invited to this meeting. No invitation to the meeting or information was requested from the one service which had known Adult Q the longest – namely her GP practice.

149. Bracknell Forest Adult Safeguarding Board has a policy on self-neglect but has not published practice guidance, unlike some other councils in Berkshire[17]. It would be helpful to review the available information on self-neglect and the Multi-Agency risk arrangements to make them easier to find and more useful.

Childrens Safeguarding Issues

150. From the information provided by the family, it would seem that Adult Q's youngest daughter left her full-time care around the time she started secondary school. Care of the child was shared between her grandmother, her father and older sister. As her grandmother became progressively unwell, she moved to live with her older sister permanently. Adult Q's eldest daughter had moved out of home as a young adult sometime in 2020.

151. This was not a formal connected care arrangement[18] and there was no input or support from Children's Social Care, although some health agencies seem to have been under the assumption that this was a formal and sanctioned arrangement.

152. A further cause of concern is the lack of investigation of the alleged rape of Adult Q in her own home by a person known to her. One of Adult Q's reasons for not contacting the Police was that her abuser had threatened to assault the youngest daughter in retaliation if Adult Q made a complaint. The threat of a sexual assault against a child should have priority over the request from

[16] CPE - Common Point of Entry, CRHTT - Crisis Resolution Home Treatment Team.
[17] Slough Supporting adults who self-neglect: Multi agency protocol and practice guidance
[18] a Connected Care arrangement (also called Kinship Care) is usually a private arrangement between parents, a relative, friend, or other "connected person." Bracknell Forest has procedures which explain when the local authority would become involved. See Placements with Connected Persons

Adult Q to let the matter drop.[19] In respecting Adult Q's wishes the hospital potentially left her youngest daughter vulnerable.

Carers Assessment

153. It has been acknowledged by family members and others who knew Adult Q's mother professionally that Adult Q had always been dependent on someone else to support her whether it was her partner, mother and latterly her daughter and other extended family. Adult Q's mother's employment by the local authority may have contributed to their shared reluctance to seek formal help.

154. A carer's assessment would have been particularly relevant for the situation that her eldest daughter found herself in following the death of her grandmother (Adult Q's mother). There were limitations to the care that the eldest daughter could provide; she worked full-time, including nights and could not always be there on demand. In these circumstances, a carer's assessment may have unlocked further support and created an awareness of Adult Q's long-term needs rather than responding to the succession of overdoses.

155. This is another example of arrangements that may have followed from the Multi-Agency Risk Management meeting referred to above.

The family as a resource.

156. It is notable in reviewing the IMRs produced for this case that there is no mention of wider family save for when they have reported an overdose. Yet some members of the family were involved either through supporting Adult Q directly or supporting her children for many months before her death.

157. There are legal and procedural obstacles in place which inhibit sharing of information without explicit consent. But these can be addressed proactively; for example, the GP practice had no registered next of kin for Adult Q. A conversation about an appropriate person may therefore have been the vehicle for discussing what information could be shared.

158. It is of course speculation to reflect on how an invitation to become involved in supporting Adult Q would have been received. In conversation with the Overview Report author, it seems likely they would have engaged positively. Engaging the people who knew her best to look at the barriers to Adult Q accepting help was worthy of consideration.

[19] Bracknell Forest Multi-Agency Safeguarding Arrangements Procedures Manual Responding to Abuse and Neglect

Barriers to engagement in treatment programmes

159. There are some widely recognised barriers to individuals feeling able to engage in treatment for their alcohol dependency. Many of these areas would have formed the content of therapeutic discussions with Adult Q and she agreed to participate. Being in the privileged position of having information from agencies and the views of some family members who are close to Adult Q it is possible to reflect on how these factors likely affected her decision-making and what could have been done differently.

160. In brief, the main reasons people struggle to engage in treatment programmes are shame and stigma, the perception that treatment is unnecessary, fear of giving up drinking or wanting to keep drinking, difficulties in accessing treatment and lack of faith and/or knowledge of treatment options. These factors were all relevant to Adult Q to differing degrees. They would indicate that an approach which relied on her self-referring or opting into treatment of her own volition would be unsuccessful.

161. A negative self-image and disproportionate concern for the opinion of others would seem to be a long-standing feature of Adult Q's personality. In the period under review, there are several occasions where Adult Q declined to accept help for fear of disappointing her mother or embarrassing her children. It is suggested that one of the barriers to her being able to talk about problems to her GP was because he worked closely with Adult Q's mother and the fact that Adult Q asked for help would be an embarrassment to her.

162. As mentioned above, one of the best opportunities for encouraging Adult Q to become involved in therapeutic services probably occurred during her employment at the primary school in 2020. She had a good relationship with her employer and colleagues, they were offering regular support including contacting agencies with her or on her behalf. They were also in a position to work through any anxiety on Adult Q's part. Paradoxically, people may be reluctant to accept help from people they hold in high regard for fear of disappointing them. Adult Q's decision to resign from the school may have been the final expression of this.

Conclusion

163. Adult Q's death was an important loss for her family. Those closest to her were well aware of the cost of her alcoholism and the gradual eroding of her self-esteem and place within her family.

164. Adult Q's death also illustrates some of the strengths and weaknesses in the current safeguarding and treatment systems available in Bracknell Forest. On a first-order level, communication between health agencies about Adult Q as

a patient seemed to have worked well; notifications were passed around promptly and some information about immediate needs was shared efficiently. However, Adult Q's case also reveals significant gaps; the lack of action following the series of safeguarding notifications, the failure to recognise self-neglect as a form of abuse, confusion about consent and a corresponding failure to convene a multi-agency risk assessment suggests that knowledge of these procedures needs to be further embedded in frontline practice.

165. Adult Q's reluctance to give consent was also a barrier to sharing safeguarding information about the possible risk to her youngest daughter. The information Adult Q had shared about the possibility of a threat to her daughter should have overridden her reluctance to give consent. At the time professionals did not have clear information about where the youngest daughter was living and the possibility of further contact with the alleged abuser. Under these circumstances, a safeguarding referral would have been appropriate.

Recommendations

1) This review has been informed that Bracknell Forest Safeguarding Board has recently reviewed its policy and procedure on self-neglect. The Board should take steps to assure itself that all relevant partners support this through appropriate training and awareness raising for all staff who are likely to come across these issues in their day-to-day work. From the evidence in this review, key staff will include Adult Social Care, Community Mental Health and the Ambulance Service. It is recommended that their training is prioritised.

2) Bracknell Forest Safeguarding Board should continue to seek assurance that safeguarding notifications and referrals are being shared with and recorded by Adult Social Care.

3) Consideration should be given to developing a threshold whereby multiple safeguarding notifications/referrals should trigger a Multi-Agency Risk Management Framework meeting or equivalent.

4) Agencies raising safeguarding concerns or making notifications /referrals should ensure that basic information e.g. composition of family, relevant addresses, next of kin etc, is included and corroborated wherever possible. Relevant partners in the context of this review would include Primary Care, SCAS, Schools, and ASC.

5) Allegations of domestic abuse where there is the possibility of an ongoing threat to either the victim or third party should be referred to the Police in all cases.

6) Within Bracknell Forest Safeguarding Board's review of the Multiagency Risk Framework, consideration is given to the findings of this review and:

    - Opportunities to strengthen the role of family members
    - where there are adult safeguarding concerns, the merits of the facilitation of further family involvement, based this on the family group conference model (or similar).

Relevant recommendations from previous reports.

Adult P

Recommendation 1: Agencies are recommended to review their guidance on professional curiosity and assess its effectiveness with frontline practitioners through a process of open feedback and/or focus groups. This feedback should factor in the development of future guidance to practitioners.

Adult L

Recommendation 7
The Safeguarding Board is assured that relevant partner agencies ensure:

- Relevant staff/volunteers are familiar with the Safeguarding Board's Risk Management Tool. Where the tool is not used, agencies should ensure an effective risk assessment is conducted and the rationale recorded.
- That relevant staff/volunteers are aware of duties under Section 42 Care Act 2014, and that safeguarding enquiries are conducted when an adult is experiencing or is at risk of abuse or neglect.

Adult M

Recommendation 9.4
The Safeguarding Board is invited to establish a task and finish group to develop alternative practice approaches to adults at risk of harm where there are concerns about the adult's ability to make decisions when they have experienced complex trauma.

Appendix 1 – Terms Of Reference

Adult Q anonymised ToR.do