Trafford Strategic Safeguarding Partnership

Miss W

Safeguarding Adults Review

April 2024

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Contents

Acknowledgement from Independent Reviewer

I should like to thank all those who contributed to this Safeguarding Adults Review (SAR).

The management of SARs places significant responsibilities on what is often a small and very busy group of Safeguarding Board staff and these demands increased and became more complex during restrictions required because of the Covid pandemic.

Changes in organisational structures, leadership, management, supervisory and direct support staff in all health, social care, police, housing, fire and rescue, financial benefits, organisations, as well as third sector organisations, have impacted severely on people who have recurring mental health difficulties, particularly those who are reluctant/unable to engage with services. It is also evident that staff in many organisations have been emotionally and physically exhausted, and continuity of care for individuals has been and continues to be extremely difficult to maintain.

I also thank Miss W's eldest half-sister[1] who made contact with me by telephone to share some information whilst grieving Miss W's death and give my apologies for the time taken to finalise the Report of this Safeguarding Adult Review.

Shirley Williams

Independent Reviewer

1 Introduction

Background to the SAR

1.1 Miss W, a white British woman, was 42 years old when she died at Wythenshawe hospital on 23rd August 2020. On 4th July 2020 concerned neighbours had alerted Greater Manchester Police (GMP) and Northwest Ambulance Services (NWAS) that Miss W was not answering her door and could be seen lying on the floor of her flat. A forced entry was made, and she was taken to hospital and placed on a ventilator. She was found to be malnourished and had burns from urine on her body as well as other serious injuries. It was estimated that she had lain on the floor for at least 4 days[2]. Although a range of assessments were undertaken in hospital, and active treatment was considered and discussed with some family members, she died whilst receiving agreed palliative care support.

1.2 An inquest into her death was opened in March 2021. Information received by Trafford Council from the Senior Coroner's Officer at Manchester HM Coroner's Court on 9.4.2021 stated that the cause of death was:

1.a Intrapulmonary haemorrhage
1.b Organising pneumonia with pulmonary aspergillosis[3] on background of emphysema and malnutrition with pressure ulcerations.
2. Alcohol-related liver disease

1.3 A SAR Referral was made by Trafford Adult Social Care on the 26th August 2020 to the Trafford Strategic Safeguarding Partnership. Records indicate that a decision to undertake the review was made at a SAR panel held on the 27th April 2021. It is unclear from the records available as to what caused the delays in processing the referral and starting the review. Learning has been taken from this and a new SAR protocol was developed and oversight panel has been put into place.

Terms of Reference

1.4 The Trafford Strategic Safeguarding Partnership SAR Panel met in a Zoom meeting for the first time on 4th August 2021. It was agreed that the SAR would look closely at information about Miss W's care and support contact and provision received from agencies from August 2019 (later discussions agreed it would be from December 2018) to her death on 23rd August 2020. Particularly significant information prior to those dates was also to be considered for inclusion in this Report.

[2] The ambulance service staff judged it as likely to be 7 days and family members have expressed their concerns that it could have been as long as 10 days.
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7210130/ The most common symptoms of cryptogenic organising pneumonia are persistent dry cough ;a high temperature –sweating and shivering feeling generally unwell; feeling short of breath loss of appetite and losing weight.

1.5 The terms of reference (TOR) and areas to be explored were agreed as documented below by the Panel to provide focus for the Review, based on the initial information from all agencies who had any involvement with Miss W.

I. The Review was to consider whether all agencies involved with Miss W recognised the level of risk she posed to herself, as evidenced by behaviours and the way she lived her life that would suggest a concerning level of self-neglect, and whether mental capacity assessments/considerations were included in risk assessments.

II. The Review was to consider whether family members' concerns of abuse by others, particularly financial abuse, were responded to appropriately.

III. The Review was to consider whether agencies and their staff involved with Miss W were aware of and able to access procedures to request a multi-agency meeting to determine responsibilities and identify a lead agency in complex cases that were judged not to meet s42 of the Care Act 2014 and the Statutory Guidance safeguarding adults' thresholds.

IV. The Review was to consider whether safeguarding concerns (referrals received by the Adult Safeguarding Team) in relation to Miss W were dealt with appropriately in line with Trafford Safeguarding Adults Partnership Procedures and whether those raising concerns were informed of the outcome.

V. The Review was to consider Miss W's mental health problems and her access to appropriate (personalised and timely) GP and primary and secondary Mental Health services and to Trafford Adult Social Care support. This was to include whether staff were aware of escalating concerns within their own agency and why partners' agencies with safeguarding responsibilities were unable to support her.

VI. The Review was to consider the impact of Covid 19 restrictions for all agencies in the last few months of Miss W's life (March-24th to August 2020), and whether her increased risks, particularly her use of alcohol, were recognised and responded to in ways that were designed to mitigate those risks.

Purpose of and methodology for this Safeguarding Adult Review (SAR)

1.6 "The Care Act 2014, sections 44 (1), (2) and (3), requires that a **Safeguarding Adult Review** (SAR) is undertaken where an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse, including self-neglect, and there is concern that agencies could have worked better to protect the adult from harm".

1.7 The purpose of a SAR, as described very clearly in the Care Act Statutory Guidance, is so *"lessons can be learned from the case and those lessons applied to future cases to*

prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account"[4].

1.8 There is no single prescribed method to conduct a SAR. The Statutory Guidance places emphasis on local decisions with a focus on "what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected."

1.9 A decision was made that a Safeguarding Adult Review should be commissioned as Miss W was identified by health, social, housing and police agencies to be an adult at risk of self-neglect and potential exploitation with care and support needs. There were concerns raised that agencies with safeguarding responsibilities had not worked well together to recognise the increasing severity of those risks and fully assess her capacity to protect herself from significant harm.

1.10 Trafford Strategic Safeguarding Partnership planned to adopt a hybrid/personalised 'Learning Together Approach'[5] that recognised the complexities of safeguarding adults, particularly those who appear to have refused support from health and care agencies.

1.11 Trafford Safeguarding Adults Partnership agreed that a SAR was required and set up a panel of agency representatives to manage the SAR process and to review the findings and recommendations. Due to changes in panel representation across the organisations which have occurred since the commencement of this review and a lack of robust record keeping, it is unclear as to why the SAR took so long to commence.

1.12 I was contacted in mid-May 2021 as an independent person[6], by a senior staff member of the Trafford Safeguarding Adults Board, to consider taking on the role as SAR reviewer and report author. I have substantial experience of safeguarding work with adults and conducting similar reviews. I was asked to chair the review panel; engage with family members where possible; meet with service practitioners as well as senior staff; and provide a SAR report after the review process was complete.

1.13 A panel of senior staff was established to guide and support the review from agencies that had some contact with Miss W. Unfortunately, there was further staff movement and vacancies that affected meetings and delayed production of this report, as well as some restrictions in face-to-face meeting because of Coronavirus lockdown restrictions.

Family Involvement

1.14 Under the Care Act 2014 and the subsequent Statutory Guidance, it is stated that the purpose of meeting family members during the SAR process is to enable them to

[4] Care and Support Statutory Guidance to Care Act 2014 published update 24th March 2016 https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding
[5] www.scie.org.uk

[6] I (author) have never been an employee of any organisation in Trafford or of those providing services to Miss W or her family.

share information they believe relevant to the review; have their views and any concerns taken into account, and to identify any recommendations for improvements in agency systems and staff practice they would like to come out of the review.

1.15 I, report author, had some telephone contact on 1st November 2021 with Miss W's eldest half-sister, who was very distressed by Miss W's death, particularly the condition in which she was found and the pain she must have suffered after lying on the floor for several days. Her eldest half-sister lives in Hertfordshire but visited family in Trafford and raised concerns along with other family members to Trafford organisations about Miss W's welfare and safety on several occasions.

Miss W's eldest sister has also had contact with the Board Manager during the later stages of the review process. It is clear that the family did not feel that their concerns around financial exploitation, self-neglect, alcohol misuse and non- compliance with medication which they reported to agencies were listened to or acted on appropriately.

Review Panel

1.16 The review panel included representation as detailed below.

Role	Organisation
Chair and Author	Independent Reviewer
Business Manager	Trafford Strategic Safeguarding Partnership
Safeguarding Support Officer	Trafford Strategic Safeguarding Partnership
Serious Case Review Team	Greater Manchester Police
Safeguarding Lead	Irwell Valley Homes
Principal Social Worker	Adult Social Care
Principal Social Worker	Greater Manchester Mental Health
Designated Nurse	Integrated Commissioning Board
Named Nurse	Manchester Foundation Trust

Practitioner Learning Events

1.17 The Statutory Guidance to the Care Act 2014 states, "professionals should be *involved fully* in reviews and invited to contribute their perspectives *without fear of being blamed for actions they took in good faith"* (italics added for emphasis).

1.18 A 'Share and Learn' event was planned on 22nd February 2022 via Zoom for staff who had some contact with Miss W and/or were in agencies with responsibilities for

safeguarding. Whilst a PowerPoint presentation was shared there were some technical problems and discussion was limited.

1.19 A 'face to face' event was arranged and eventually took place at Trafford Town Hall on 24th November 2022. A small number of staff attended and, whilst some knew of Miss W, only one had any direct knowledge of her care and support concerns. Several staff expressed concerns about safeguarding systems and high workload demand that made it extremely difficult for them to work closely with people referred to them experiencing similar issues and risks to those of Miss W. Isolation, self-neglect, excessive drinking, and reluctance to seek professional support, and long waiting lists for the 'right' services were all too familiar to them.

Additional Review/Investigation/Inspection Reports

1.20 I am unaware of any other specific reviews/inspections that have taken place in relation to safeguarding and Miss W's circumstances and death. I was provided with brief chronological information from some Trafford agencies at the beginning of the review process and more detailed Individual Agency Management Reviews were requested by the Trafford Safeguarding Adults Board manager and received by me in March 2024. Whilst these have been of great assistance in clarifying actions it has also been surprising how little engagement there was with Miss W. She rarely instigated contact with people and on most occasions refused or avoided involvement with others.

2. A Pen Picture of Miss W

2.1 Miss W grew up in her parents' home as part of a blended family, alongside her two older sisters who were fourteen and six years older than herself. Her mother experienced serious mental health problems with a diagnosis of Schizophrenia, and she died when Miss W was 23 years old. Whilst her father was noted as Miss W's next of kin throughout most of her life, her sister did not believe that Miss W had benefited from his support.

2.2 It is understood from her sister that Miss W did not share the same father as her siblings, and they had a difficult relationship with their step father. Her sister believes that this resulted in Miss W feeling like an "outsider" and distanced from them at times. This feeling had been further exacerbated at times when her sisters had taken action to access support with her mental health and she had then perceived them as the "enemy" and to be against her.

2.3 Miss W's family have described her as being a quiet, shy and private person who "wouldn't ask for anything unless things were really bad". Her presentation and willingness to hold a relationship with her family would dramatically change when she

had not been compliant with medication and again her sister feels that this was due to them having reported concerns which previously resulted in her being sectioned.

2.4 Miss W had a range of problems from childhood including dyslexia and she attended a 'Special' school. A family member said she did well academically but also experienced problem with her mental health. In her mid-teenage years, she was diagnosed with Schizophrenia and received inpatient treatment at Moorside Unit. She experienced fluctuating mental ill health and had GP and community-based support and periods in hospital.

2.5 Miss W had a close relationship with her mother and her sister indicated that "mum had wrapped her up in cotton wool". Her mother's death is said to have impacted significantly upon Miss W and it was following this that she had relocated to Scotland with her partner. This came after she became a mother in her late teens and resulted in limited support being available to her. Miss W's life during her time in Scotland became particularly chaotic and her sister suggested that substance misuse, the breakdown of her relationship and the loss of her mother had all contributed to a rapid decline in her mental health. This resulted in periods of homelessness, loss of contact with her family and ultimately her admittance to a mental health facility in Scotland in 2001. We as the panel / reviewer are unaware as to how this sequence of events impacted on Miss W however the potential effect of experiencing such trauma must be considered.

2.6 Children's Social Services in Scotland became involved with the family, as a result of Miss W's poor mental health which led to concerns that her daughter was being neglected. Her child was removed from her care and was subsequently placed in Trafford between the age of 4-5 years old on a Residence Order in the care of her auntie, the younger of Miss W's sisters. Miss W's father and her younger sister as well as Miss W's daughter continue to live in the Trafford area, and her older sister lives in Hertfordshire.

2.7 Despite her child being placed into the care of her sister, Miss W had maintained a relationship after discharge from hospital she returned to Trafford moving in close proximity to her sister and daughter. Her eldest sister described how during periods of stability, Miss W would have regular contact with her daughter and that she would participate in activities such as bathing her and reading her a bedtime story. It was only in periods of a decline in her mental health that this contact wavered, and Miss W would withdraw.

2.8 Miss W was offered and, although not always willingly, received some mental health support services over the years, including from the Trafford Community Mental Health Team (CMHT)[7]; assertive outreach; home based treatment services; and rehabilitation services. She was also an inpatient in GMMH Moorside Unit which is located in Trafford General Hospital for nearly 2 years from January 2005 to December 2006 and had 2 periods of detention under Section 3 of the Mental Health

Act in 2014. Miss W was discharged from receiving mental health support services from the CMHT in 2016 with the understanding that she would have regular contact with her GP for medication and oversight.

3. Case Chronology and system findings

3.1 Trafford Strategic Safeguarding Partnership SAR Panel initially agreed that the scoping timeline for consideration of key events and interventions leading up to Miss W's death would be from August 2019 to her death in August 2020. Following concerns raised by family members and additional information being provided by agencies to the early drafts of the SAR report it was agreed that significant earlier events indicating safeguarding concerns may have been unrecognised, and/or insufficiently unexplored, prior to August 2019. It was agreed that information and agency involvement should be looked at more closely and the scoping timeline was extended from December 2018 to August 2020.

3.2 There is information that Miss W's mother experienced mental illness and had a diagnosis of Schizophrenia and died on 1st November 2001 when Miss W was 23. The family do believe that this impacted greatly on Miss W and her own mental health.

3.3 Miss W, at the age of 23, seems to have had her first experience of being detained in hospital under section 26 of the 1984 Scottish Mental Health Act.[8] Children's Services in Scotland had some concerns that her daughter was being neglected as a consequence of her mother's poor mental health. Her young daughter was removed from her care and was subsequently placed on a Residence Order in Trafford Council area into the care of her auntie, the younger of Miss W's sisters.

3.4 Many services have been involved with Miss W over the years prior to the dates agreed for the more detailed review by this SAR (December 2018 - August 2020). These services included regular GP appointments, Rehabilitation, Assertive Outreach, Home Based Treatment Team, Mental Health Practitioner (AMHP) to enable assessment in times of crisis and, when necessary, provide detention in a place of safety.

3.5 In August 2009 Miss W was allocated a 2-bedroom flat in Trafford, rented from Irwell Valley Housing Association. She was known to some of her neighbours and whilst

[8] www.legislation.gov.uk/ukpga/1983/20/contents
Section 26 of the Mental Health (Scotland) Act 1984, is a Short Term Detention Certificate. It was recommended to be the preferred power to admit a person compulsorily to hospital for psychiatric assessment and / or treatment, for up to 28 days. It authorised detention in hospital and compulsory treatment under the Act.

It required a psychiatric assessment by a Section 22 Approved psychiatrist (experienced psychiatrist, trained in the 1984 Scottish Mental Heath Act), and the consent of a Mental Health Officer (a specially trained experienced social worker, appointed by the Local Authority).

there is evidence of them trying to provide support to her there were also strained relationships and reports to Irwell Valley Housing and Trafford Social Care staff about the poor state of her flat, as well as intermittent issues arising from her drug use and excessive use of alcohol.

3.6 In July 2013 Miss W was detained under Section 3 of the 1983 Mental Health Act[9] in the GMMH Moorside Psychiatric Unit at Trafford General Hospital. She had a diagnosis of Psychosis with an Affective Disorder. She was described as having a long history of drug abuse.

3.7 Miss W was discharged from the Community Mental Health Team, (CMHT) oversight in 2016. She was assessed as 'managing' and GPs in her GP Practice would be able to monitor her medication and provide oversight of her mental health, which had improved.

3.8 On 7th February 2018, nearly 2 years following her discharge from the CMHT service Greater Manchester Police received a report from another service user indicating that Miss W's male lodger had been drinking excessive levels of alcohol as well as smoking 'weed'. A check was made at her address by police officers. She did not allow them access into her flat but confirmed that she had a 30-year-old man living in a room in her 2 bedroomed flat with her agreement. Some family members believed that Miss W may have experienced coercion and control from this person and financial exploitation by him and others. Miss W said she had back problems for which she had medication from her GP but was otherwise 'managing' and did not want any support. Police officers were concerned about her presentation and made a referral to the Community Mental Health Team (CMHT) again. Mental health staff confirmed that they knew her and that concerns over her situation were 'being managed.' It is not recorded whether any direct contact from CMHT staff was made with Miss W.

3.9 From July 2018 to July 2020 several people, including family members, raised concerns about Miss W's safety and welfare with Greater Manchester Police, Trafford Division[10], Irwell Valley Housing, and a range of Health and Care organisations. This is evidenced from the family testimony and individual agency reviews.

3.10 In December 2018 further concerns were raised by telephone by a 'friend' to Trafford Emergency Duty Team (EDT), the Northwest Ambulance Service (NWAS), and Trafford Adult Social Care (ASC). The friend reported that Miss W was vulnerable, neglecting herself, drinking heavily, had infrequent contact with family members, was at risk of falling, and didn't have access to a phone. There is some information that ASC staff tried to make some contact with the friend who had raised these concerns about Miss W but without response. The information which had been received from NWAS was forwarded onto her GP, but no further action was recorded. This

[9] Section 3 of the Mental Health Act is commonly known as treatment order, it allows for the detention of the service user for treatment in the hospital based on certain criteria and conditions being met. These are that the person is suffering from mental disorder and that the mental disorder is of a nature or a degree which warrants their care and treatment in hospital and that there is risk to their health, safety of the service user or risk to others. It also requires that the treatment cannot be given without the order being in place and that appropriate treatment must be available in the setting where it is applied.

[10] GMP Records show no Police contacts recorded from 2018 until her death.

information was not regarded as a safeguarding concern at a level that would warrant a Section 42 Care Act safeguarding consideration.

3.11 Adult Social work case notes record that, "*no contact was achievable at this time with either Miss W or the unidentified referrer.*" Adult Social Care staff sent the information to Miss W's GP to consider the need for consent to refer her for possible exploration of support to manage her excess alcohol consumption. Miss W's case was closed to Adult Social Care staff at this point. There does not seem to have been any discussion/concerns forwarded to staff with specific adult safeguarding assessment responsibilities despite the risks described by the friend. It is acknowledged in the Adult Social Care response that further action should have been taken at the time of this referral.

3.12 The GP did attempt contact with Miss W via phone and letter with no response and a referral was made to Achieve given the concerns raised by Adult Social Care. There is a learning point here that on reflection a home visit could have been attempted to review patient and complete capacity assessment if required under the Mental Capacity Act 2005.

3.13 Irwell housing have documented two contacts on the 6th March 2019 for pipe repair work and 11th June 2019 for annual gas servicing both of which did not log any welfare or property concerns.

3.14 On the 7th July 2019, the Greater Manchester Mental Health (GMMH) Helpline was contacted by Miss W's elder sister, and she was given information and advised to contact her sister's GP. This was done and a GP, visited Miss W at her home after being contacted by her daughter as well as her sister on 8th July 2019. Both daughter and sister expressed concerns for her welfare as she wouldn't allow them into her flat, but they could see she was in a neglected, unwashed state. The GP gained access and arranged for an ambulance to take Miss W, accompanied by family member(s) to Trafford General Hospital for an urgent Mental Health Review by the Crisis Team. Miss W was admitted to Trafford General Hospital for an urgent Mental Health Review by the Crisis Team. She was judged to be too intoxicated to have a mental health assessment and remained in hospital for further assessment.

3.15 On 9th July 2019 staff from Trafford & South Manchester Mental Health Liaison Service completed an initial mental health assessment. It seems that her harmful level of alcohol consumption was assessed as her main problem, and she was referred to the Alcohol Liaison Team. They recorded that she told them that she drank 2.5 litres of white cider per day (more than double the amount that would be regarded as medically safe drinking), had lost weight and had no money following a bank account scam (her sister confirmed that had happened). Miss W was prescribed Thiamine to treat her symptoms of Vitamin B1 deficiency believed to have developed as a result of her excessive alcohol intake.[11]There is no evidence that the concerns around financial abuse were reported to the Police or as a safeguarding to Trafford Council and no investigation therefore took place.

[11] www.adf.org.au/insights/alcohol-related-thiamine-deficiency

3.16 On 14th August 2019 Miss W had a review with a GP, who checked her blood pressure and gave advice on smoking cessation and alcohol consumption. It is unclear whether Miss W was compliant with administering the Thiamine medication as this is not recorded within the consultation.

3.17 On 4th October 2019 concerns were once again raised by neighbours that Miss W's home was in a neglected state, "infested with flies" and that she had no working heating. Miss W had allowed this neighbour access to her property to change a light bulb who then contacted Irwell Valley Housing via email.

3.18 On 7th October 2019 in response to the neighbour's concerns, an Irwell Valley Tenancy Management Officer (TMO), visited Miss W but was not allowed beyond the doorstep. Miss W said that a new central heating boiler had been fitted but she didn't know how to use it. He recognised her vulnerability and assured her that he wanted to help her and would arrange for someone to visit to demonstrate how to use the boiler. Miss W also agreed for the TMO to make a referral to request a visit from a worker at the Trafford Initial Assessment Social Work Team

3.19 A follow up visit from Irwell Valley staff was undertaken as planned and agreed with Miss W on 15th October 2019. He noted that the flat was dark and unkempt but there was no evidence of hoarding. A further appointment was arranged for the 23rd October 2019. however, Miss W declined social care input at that appointment. The provider notes that there is no documentation regarding the 23rd October visit and this could therefore have either been due to staff absence or a refusal of entry by Miss W.

3.20 During a visit on the 6th November 2019, Miss W agreed that a referral to social care could be made, and this was reported to have been sent on the same day. It was documented that Miss W was not receiving any mental health support services, and he also wanted the finance team to check her eligibility for assistance given her low income. It also seems that either no one had visited her at her flat or they were unable to gain access to assist with starting the boiler even though it was now November.

3.21 On 1st December 2019, the TMO visited Miss W's home again. The heating and hot water had been fixed and he helped her to get her boiler thermostat working with a payment card. There had been no improvement in the state of her flat.

3.22 The referral to adult social care was chased on the 10th December 2019. The response from Adult Social Care on both occasions was to attempt to contact Miss W by phone and a letter sent to her asking her to make contact. It was nine days after the follow up call from Irwell Valley that a worker was assigned, and a joint visit arranged.

3.23 On 2nd January 2020 the TMO had contacted Adult Social Care and wrote to Miss W to say he would be visiting her with a social worker. It was not until 14th January 2020 that the joint visit was made. This resulted in agreement that a further visit would be conducted so that consideration could be made for a care and support plan to be put in place to support Miss W. This visit did not take place and by March 2020, Coronavirus infections, Covid lockdowns, staff absences, and general uncertainty, began to adversely affect direct contact to and from all services, unless serious, high-risk events, were recognised and reported.

3.24 On 17th February 2020 Miss W's elder sister contacted the GP surgery expressing her concerns about her sister's ability to take care of herself, this included details of self neglect, alcohol misuse and financial abuse. A GP made a home visit, but she wouldn't let him in. They had a conversation through an open window, but she declined any further intervention and the GP's assessment was that she had the mental capacity to make that decision[12]. The GP surgery IMR confirms this took place and it is recorded as taking place in the GP notes of the visit however these notes are limited and do not confirm the decision that capacity was being assessed for.

3.25 On 13th March 2020, 26th May 2020, 27th May 2020 and 28th May 2020 further invites were sent, using the same communication methods (no direct visits), for Miss W to attend the surgery, but again there was no response from her and no recorded follow up from the GP Practice

3.26 It is of significance that coronavirus and its potentially serious health outcomes began to be recognised at the end of February 2020 and discussed in the UK parliament on 4th March 2020.[13] The Government message was, "*now is the time for everyone to stop non-essential contact and travel"*, and the first legal enforced lockdown began on 26th March[14]

3.27 On 4th April 2020 and again on 9th April 2020 the TMO sent emails to the social worker asking for updates on progress about arranging for the support package to be offered to Miss W, but he didn't receive any response.

3.28 On 17th April 2020 the TMO emailed Trafford Initial Assessment Team (IAT) to find out what was happening with the support package as he had heard nothing from the social worker. This contact was recorded by ASC but there is no evidence of further escalation having occurred.

3.29 During this same time period (September 2019 to 17th February 2020) of the TMO raising concerns with the social worker, Miss W was invited by text, phone calls, and letters from her GP Practice to attend for an Annual Health Review on 10th September 2019. She did not respond. Over 4 months later she was contacted by the same communication methods to attend the surgery on 2nd and 7th February 2020 but again no response was received.

3.30 On 4th July 2020 an alert was made by neighbours to police and ambulance services after they became concerned that they had not seen Miss W for several days, that there was a stench coming from inside her flat and that her cat could be heard squealing. There was no response when neighbours tried to contact her, and her legs could just be seen as she was lying on floor. A forced entry was made by Police and Ambulance staff and Miss W was found, collapsed and in a near-death state on the floor in her hallway. There was evidence of alcohol and non-prescribed drugs believed

[12] www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/

[14] timeline-coronavirus-lockdown-december-2021 (instituteforgovernment.org.uk)

to be Cannabis in her flat, but no evidence of anyone else being present or living in her flat. Miss W died in hospital just over 6 weeks after admission.

3.31 Miss W's breathing was found to be very shallow; it was not possible to take her blood pressure her pulse was too low and there was no way of taking a blood sample as her veins were not visible. She was in a soiled nightgown, barely conscious, pale and malnourished, and had marks on her legs, which resulted from urinary burns, and pressure sores were developing on her shoulder.

3.32 Paramedics estimated that she had lain on the floor for approximately a week. The flat was described as extremely dirty, with cat faeces and hair and general dirt present.

3.33 Miss W was taken to Wythenshawe Hospital, part of Manchester University Hospital Foundation Trust, where she was placed on a ventilator. Miss W was found to be very dehydrated and diagnosed with kidney failure. She received emergency surgery for 'compartment syndrome,' a condition of muscle tightening which cuts off blood supply[15]. The operation was described as successful as it relieved some of her pain, but she remained in a critical condition.

3.34 GMP and NWAS officers concluded that there was no evidence of drug use, excess alcohol misuse, or any other person having been involved in actions that had led to Miss W's injuries and collapsed state. The Police Officer attending submitted the appropriate safeguarding notification namely CAP referral to Adult Social Care expressing concerns over Miss W's level of vulnerability.

3.35 A Safeguarding Referral was made by the Manchester Foundation Trust Hospital Safeguarding Team on the 27th July 2020. This referral remained open at the time of Miss W's death.

3.36 Over the next 7 weeks Miss W underwent several clinical assessments and considerations for medical interventions. Following discussions with family members[16] and the assessment that she would continue to need ventilation and be left with a high level of physical and mental disability, it was agreed palliative care was the most appropriate action. Miss W sadly died on 23rd August 2020.

3.37 Given the circumstances of her death and evidence that she was an adult at risk with care and support needs, a recommendation was made to the Safeguarding Adults Board under section 44 of the Care Act. The Care Act 2014, sections 44 (1), (2) and (3), require that a mandatory Safeguarding Adult Review(SAR) is undertaken where an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse, including self-neglect, and there is concern that agencies could have worked better to protect the adult from harm.

3.38 Whilst Miss W had experienced serious health deterioration in the months prior to the start of the Covid Pandemic in March 2020, the impact of the restrictions on

[15] www.nhs.uk/conditions/compartment-syndrome

[16] Family members made clear that they were led by clinical advice in respect of the best options for Mss W's treatment and care.

movements and meetings with other non-household members in place must be considered in the context of this review. It is unclear how these restrictions impacted on Miss W's lifestyle and wellbeing, given her longstanding reluctance to engage with health and support services and with some of her family members. Some of these restrictions also impacted on routine oversight by staff in health, social care, police, housing and other people-facing health and care organisations. The severity of Miss W's risks was not always recognised and/or well communicated between organisations with safeguarding responsibilities, and some interventions and plans for support were not carried out and/or adequately recorded.

4. Individual Agency Analysis of case and system finding

Greater Manchester Mental Health (GMMH)

4.1 GMMH had limited involvement in the scoping period and Miss W was not in receipt of ongoing support from mental health services. Miss W was not seen at her address so there was no evidence of the level of self-neglect present in this case available to mental health services.

4.2 The call to GMMH helpline 7th July 2019 made by Miss W's sister was responded to providing her with the appropriate advice needed to access support for her sister. It covered all services available to her, including how to access an assessment under the Mental Health Act and how to raise a safeguarding concern with the Local Authority. Appropriate information was forwarded to the GP for consideration.

4.3 Later in July 2019, Miss W was sent to A+E by her GP after a home visit. The GP sent Miss W for a Mental Health Act assessment citing self-neglect and excessive use of alcohol. Miss W was too intoxicated to assess, and the assessments took place the following day. This is accepted practice as it is impossible to accurately determine mental state where alcohol is a factor.

4.4 The assessments in A+E by Mental Health liaison and Alcohol liaison teams relied heavily on FW self-reporting her symptoms and alcohol misuse. Although it is important to elicit the interviewees point of view, it is not always the most reliable information to inform a risk assessment or to judge vulnerability. There was information available from Miss W's GP that described her non-compliance with medication and her self-neglect. Using this information to inform an assessment of risk would have led practitioners to doubt that FW would follow the advice they offered her around her alcohol use and to consult with her GP. At this point consideration of Miss W's capacity may have added to an understanding of her presenting problems- whether she was deemed to have capacity or not.

4.5 Miss W's vulnerability to self-neglect and her inability to acknowledge concerns for her mental state and harmful alcohol use indicated the need to submit an adult safeguarding referral to the Local Authority. This did not happen, so the opportunity to place this case in a multi-agency setting was missed.

Areas of Good Practice

The call to GMMH helpline was responded to supportively and offered useful advice. It demonstrated how important it is to listen to and respond to concerns raised.

Information sharing with the GP by all practitioners was timely and in accordance with policy.

Lessons Learned

FW would have benefitted from a dual diagnosis assessment of her mental health and alcohol misuse needs. Trafford Partnership convenes fortnightly meetings to discuss dual diagnosis cases and provide advice to practitioners. This was not available at the time of this incident but would have been a supportive forum to look at issues around poor mental health and alcohol misuse, especially in relation to capacity and decision making.

The need to make safeguarding referrals where self-neglect is suspected/reported is made clear in GMMH's Safeguarding Adults policy and is included in the training suite delivered by the Learning Hub, GMMH. This message needs to be reinforced for practitioners.

Understanding capacity in the context of alcohol misuse is a training need for teams. It was good practice to wait to assess FW considering her intoxication. However, the impact of FW's alcohol misuse on her executive capacity was not assessed.

Single Agency Recommendations

Resources are needed to support practitioners to better understand self-neglect and how to work effectively with these cases. Self-neglect and Hoarding Toolkit have been circulated to the Directorate on 27th February 2024.

Capacity and alcohol misuse could usefully be revisited in team meetings. Blue Light manual and "Fluctuating Capacity and the Law" were circulated to the Directorate on 27th February 2024.

Greater Manchester Police (GMP)

4.5 During the time frame of this review GMP had just one contact with Miss W which occurred following the call from her neighbour on the 4th July 2019. On this occasion GMP were contacted by the NWAS. On attendance GMP recognised Miss W's vulnerability and therefore completed a CAP record which was shared with partner agencies outlining the responding officers' concerns. A mental capacity assessment was not completed as Fiona was unconscious.

4.6 GMP hold no information regarding the families concerns regarding financial abuse.

4.7 It appears from the 4th July 2020 incident that officers were aware of and able to access procedures to request a multi-agency meeting to determine responsibilities and identify a lead agency in complex cases that were judged not to meet s42 of the Care Act 2014 and the Statutory Guidance safeguarding adults thresholds. as the matter was discussed at the Daily Risk Management Meeting. Information was shared via the established methods CAPS and actions agreed re the lead professional. Unfortunately, Miss W passed away shortly afterwards.

4.8 The Covid pandemic had no impact in relation to the GMP response to Fiona's welfare when contacted on 4th July 2020.

Lessons Learned
A_G risk matrix was not utilised in relation to the officer's vulnerability update on the CAP record. However, the matrix was only disseminated in May 2020, so in July 2020 it had yet to be embedded in practice. The Op Quest update contained all the relevant material, and the information was shared appropriately with partner agencies present at the DRM on the 6th July 2020.

Adult Social Care

4.9 Records evidence that Adult Social Care's (ASC) assessment service involvement was intermittent between December 2018 through to July 2020. During this period, ASC structure consisted of a Screening Team which was a first point of entry for all referrals into the ASC system. Screening would then take place and if further

involvement was needed the referrals would be passported through to the appropriate area of the service. At the time of the referral a pilot was also being run within ASC, introducing the 3 conversations model; what is now the Let's Talk strength's-based model. This pilot was adopted by the Central Neighbourhood of the service, the area in which Miss W resided. The 3 Conversations pilot meant that all referrals into the system went straight to the Central Team without any involvement from the Screening Team.

4.10 Throughout the period of involvement, it has been documented that there were no adverse pressures on the service when the initial contact was received by ASC in 2018. In 2020 the COVID-19 pandemic placed increased pressures on ASC. The Central Neighbourhood Team assisted in supporting colleagues from other areas of the service who were struggling due to the increased demands on the service and the sickness levels as resulting the pandemic. Additionally, the Senior Practitioner within the Central Team had periods of sickness throughout this timeframe; impacting on the supervision provided to staff. It has been identified through discussion with the Service Manager of the team that the member of staff had a very large case load at the time of involvement and discussions were being held between the Service Manager and the Social Worker with regards to workload management.

4.11 In 2021 the service completed a restructure with the disestablishment of the Screening Team, creating the Safeguarding Hub, resulting in a central point of referral for all safeguarding activity for ASC. This change saw the discontinuation of the Let's Talk pilot and introduced a new way of working across the service; resulting in all non-safeguarding work being received directly by the service in which residents live.

4.12 The service has a duty to assess individuals who may have care and support needs under the Care Act 2014 and has subsequent duties depending on the outcome of that assessment. This could include amongst other things, provision of information, advice, services, and a plan of support. This process is commenced via a conversation which often necessitates a home visit, depending on the urgency and the level of associated risks.

4.13 The involvement of Adult Social Care services would usually require the consent of the person for our input except in some circumstances where there are safeguarding concerns, which was the case in this instance. Regardless of this it is clearly documented within the referral received from the Northwest Ambulance Service that consent was given.

4.14 It is not clear from the records why there was no assessment undertaken at the point of the contact stated above in December 2018 and the records show no explicit consideration of the duty that the service must undertake proportionate enquiries, including whether the threshold was met for a safeguarding response under the Care Act 2014 which would initiate the consideration of a multi-agency protection plan.

4.15 There were no adverse pressures on the service at this time which could explain why there was no record of the decision making for this case, the reason for the closure, why there was no assessment and why a safeguarding response was not considered necessary.

4.16 An unannounced visit should have been completed to Miss W following the referral being received. There was a clear focus on the need for consent without any further professional curiosity or acknowledgement of legislative frameworks such as Section 42 of the Care Act 2014 or the Human Rights Act 1998.

4.17 Through involvement during the period 2019 -2020 there is evidence of significant delays in Adult Social Care's response following contact from Miss W's housing provider. Additionally, there does not appear to have been any professional curiosity regarding the previous concerns raised or acknowledgement that this was not the first contact received by the service with concerns around Miss W's wellbeing.

4.18 Record keeping throughout this process was limited so it is very hard to identify why there was such significant delays in responding to the contact made with the service. It should have been expected that when contact was made in November 2019 a visit be completed to follow up on the concerns raised especially as contact was not possible over the phone.

4.19 It is not clear from the records why there was no assessment completed at the point of the joint visit in January 2020 and the records show no explicit consideration of the duty the service has to undertake proportionate enquiries, including whether the threshold was met for a safeguarding response under the Care Act 2014 which would initiate the consideration of a multi-agency protection plan. There is no indication within the records that Miss W had not consented to any offers of support from the service at that point. The follow up letter to Miss W sent on the 3rd July stated the Social Workers perception that at that point Miss W "was managing reasonably well". Miss W's views and wishes are not clear within the documentation.

Lessons Learned

There have been changes to process since Miss W was referred to ASC including the creation of the Safeguarding Hub where all safeguarding referrals would be sent to where statutory safeguarding obligations are considered. Given at the time the Northwest Ambulance Service referral was identified as being safeguarding this would have been referred into the Hub.

Additionally, it has been recognised by the assessment service that refresher training on the Care Act 2014 is required for all assessment staff, this is currently in the process of being commissioned and will be rolled out across the directorate.

Lastly it is important to note that the assessment service has a development plan in situ and a review of the Let's Talk model and duty function forms part of this development work.

Single Agency Recommendations

Many of the changes which have been implemented or are part of scheduled work form part of the recommendations. The implementation of the Safeguarding Hub is complete, and this will continue to remain under review to ensure the effectiveness and efficiency of the service.

- Ensuring Legal Literacy within ASC workforce.

Work to commence in May 2024 and aim for completion in July 2025. The effectiveness will be identified through regular case file audits.

- Review of Duty Function and Let's Talk Model

Support in ensuring a consistent approach to duty across the service. Duty review completion in June 2024. Let's Talk to commence in April 2024 completion in October 2025.

Irwell Valley Homes

4.20 Irwell Valley Homes is the landlord of Miss W. It is a social housing landlord operating across Greater Manchester. It owns and manages the Sale West estate in Trafford where Miss W lived.

4.21 During the review period, Irwell Valley had limited contact with Miss W, however records advise that the agency attempted to contact her sister at FW's request, with regards rent payment issues. This does not appear to have generated a response from the family member.

4.23 Concerns were raised by a neighbour of Miss W on 4th October 2019. A subsequent visit by the Neighbourhood Officer, GM, to Miss W's home led to a request for an assessment of Miss W's needs by Trafford Adult Services on 6th November 2019. A joint visit was made on 14th January 2020, with a proposal to carry out a further assessment once the case had been raised at a team meeting. The TMO continued to have concerns about Miss W's welfare and struggled to contact the social worker.

The social worker contacted the TMO on 3rd July 2020 to advise that he had not been able to contact FW.

4.24 Irwell Valley have no records of concerns raised by neighbours at any other point.

4.25 The housing provider have reviewed Miss W's rent payment patterns. She was in receipt of Housing Benefit, which was paid directly to Irwell Valley, but she had to pay a shortfall in her rent each week for underoccupancy charge (bedroom tax) which in 2020 would have been around £12 per week. She paid this on an ad hoc basis, by payment card (assumed to be at the post office). She would occasionally slip into minor arrears, which would then be paid, with arrears never exceeding £150. The threshold at the time to trigger a home visit by a member of the incomes team would be nearer £800. Miss W's rent payment history would not trigger any concerns around financial abuse under existing policy.

Lessons Learned
Since the date of this incident Irwell Valley Homes has established a dedicated tenancy sustainment team (est. June 2020) which supports customers identified with complex needs. IVH colleagues handling safeguarding concerns are familiar with formal Safeguarding Escalation Processes should their enquires with adult social care fail to lead to action/intervention by ASC. Operatives from the Homes Team (repairs colleagues) all receive two yearly safeguarding training delivered in person by Head of Independent Living and Homes Team Manager. Before a job can be closed on their handheld device, they are required to confirm that there are no property condition or safeguarding issues at the customer's home.

General Practitioner (GP)

4.26 Miss W was identified as a vulnerable individual with a background of alcohol misuse, mental health illness and family concerns relating to self-neglect. The practice tried to communicate with her by contacting her on multiple occasions but had been unable to get her to engage with care and support. As Miss W did not respond to texts, phone or letters, it would have been beneficial if we had details of another contact to

discuss medical information, such as family member, but there was no record of any consent by Miss W. Family raised concerns of self-neglect in February 2020 and a GP did a home visit to assess her, but Miss W declined to let him in her home. She was assessed from her window as having capacity and the GP did not report any immediate concerns about her safety. It is acknowledged that discussions with family and other agencies that may have been involved in her care would have been beneficial alongside a referral to the adult safeguarding team at this time.

4.27 The practice has identified the GP assessing capacity when seen face to face at home visit and their recording of the assessment as good practice, however the details of the capacity assessment are not recorded in Miss W's records and the assessment of capacity through a window is questionable.

Lessons Learned
Sharing information and seeking additional information from family and any other agencies along with a referral to adult safeguarding team. Being able to see the living conditions of Miss W may also have prompted urgent action if evidence of self-neglect. Covid 19 pandemic resulted in less face-to-face assessments during the subsequent period and there was a restriction on home visits which would have alerted us to an escalating problem.
Single Agency Recommendations
Practice to review that all patient/public facing staff have accessed MCA training appropriate to their roles. The importance of multidisciplinary approach and information sharing of concerns when self-neglect is a risk to be encouraged and embedded within the practice.

North West Ambulance Service (NWAS)

4.28 North West Ambulance Service record two contacts with Miss W in the period considered for this review.

4.29 The first on the 9th December 2018 where a Safeguarding concern notification was shared with Adult Social Care due to the crews concerns that she was vulnerable, isolated due to having no phone or support network nearby. The crew noted that she

was drinking, had a history of Schizophrenia and was taking medication at the time. NWAS Crew requested that Adult Social Care make contact to signpost Miss W to any relevant local services and an out of hours GP referral was made.

4.30 On the 4th July 2020, NWAS responded to a 999 call received from Miss W's neighbour who had smashed the window to gain entry. Police were called to the scene. NWAS note that the Patient Report Form is missing from the records and so the following information was taken from the control log. Upon arrival the Ambulance Crew observed Miss W to be unconscious and unable to communicate. She had urine burns from head to toe and the hospital were pre-alerted. Miss W was transported to hospital using blue lights and sirens.

4.31 NWAS have not identified any individual agency learning and it does appear that appropriate referrals were considered and made.

Manchester Foundation Trust (MFT)

4.32 Manchester Foundation Trust record Ms W as having been taken into the Hospital A&E as a red standby with concerns around inadequate breathing on 4th July 2020. Ms W was found to have necrotic pressure areas to her left shoulder, chest, abdomen, hip and knee and received a diagnosis of Hypothermia. She was transferred to the Acute Intensive Care unit where she remained until her death on the 23rd August 2020. All services provided to clinical need in a timely manner.

4.33 MFT notes indicate that a referral received by safeguarding team due to self-neglect on the 27th July 2020 was then sent to Trafford Local Authority (LA). Advice was documented on electronic patient records for staff to liaise with Trafford Local Authority when discharge planning. This referral to Trafford Local Authority was said to have been completed correctly in line with MFT Policy.

4.34 During her admittance, Ms W was provided given adequate care. Respiratory Physiotherapy team provided advice regularly for nursing and medical staff regarding the management of her needs.

5. Reviewer Analysis of case and system finding

5.1 The Practice Guidance developed by the Social Care Institute for Excellence (SCIE) to assist agencies carrying out Safeguarding Adult Reviews (SARS) as required by the Care Act 2014, suggested that a SAR needed to achieve understanding of the following:

- What happened?
- Were there any errors or problematic practice and/or what could have been done differently?
- Why did those errors or problematic practice occur and/or were things not done differently?
- What remedial action needs to be taken in relation to the findings to help prevent similar harm in future cases?

5.2 The earlier section of this report provides a summary of the 'What happened' key events and interventions in Miss W's life. A relative described Miss W as "a very private person'. She went through periods when she declined assistance, and also periods when her family described her as confused. She refused access to her home on many occasions to both family members as well as support staff. She appeared to choose to isolate herself from contact with others so there is little verifiable information, particularly about how she felt about herself and what she valued in her life. In the last few months of her life family members described her as talking to herself and not knowing what day/time of year it was. They felt that their concerns were not taken seriously by agencies and no proper assessments were undertaken.

5.3 It can be identified now information has been brought together in this SAR that Miss W's response to staff, that she was 'managing' when family, neighbours, and friends raised concerns about her, was perhaps something of a self-protection mantra (she wanted to be seen as an independent person making her own decisions). This was insufficiently assessed and challenged, and concerns were not being routinely shared and followed up between agencies with safeguarding responsibilities.

5.4 It is evident from the chronologies prepared at the request of the Trafford Strategic Safeguarding Partnership (TSSP) following Miss W's death, that several organisations had only intermittent and rarely face to face contact with her. Whilst there were concerns and some shared information, it is acknowledged that no organisation had a full picture or understanding of her lifestyle and risks. Referrals were being made between agencies following some of the specific issues raised by neighbours and some of her family members. However, the whole picture of her traumatic experiences and increasingly risky way of 'managing', particularly in relation to excess alcohol use, was not being fully recognised. The jigsaw pieces were visible, but no person/organisation seems to have seen it as their role to bring the picture together.

5.5 There are several missed opportunities where more sharing of information between agencies with safeguarding responsibilities might have made some positive difference to Miss W accepting support. This might also have led to more sustained professional curiosity about how she viewed herself and the 'choices' she was making about how she lived and enabled closer attention to concerns raised by family members and friends. One example was the period between 9th and 10th December 2018, when a female describing herself as Miss W's friend raised her concerns. This person was persistent: she made several calls to the Trafford Council's Emergency Duty Team (EDT), the Northwest Ambulance Service (NWAS), and Trafford Adult Social Care (ASC). This female reported that Miss W was vulnerable; she was neglecting herself; had increased her alcohol consumption; was at risk of falling; did not have access to a phone; and had infrequent contact with family members. She believed that Miss W was not suicidal but needed mental health support, which she had not received since 2016.

5.6 It appears that no agency recognised that the information they were being given by the friend warranted being investigated as a safeguarding concern and a face-to-face unannounced visit to Miss W should have been undertaken. Trafford Council's own analysis of this contact during this SAR identifies that that there was no explicit and recorded consideration of the duty the Services had to undertake proportionate enquiries, including whether the threshold was met for a safeguarding response under the Care Act which would initiate the consideration of a multi-agency protection plan. There is little indication that with a consistent person-centred approach (as shown by Irwell Housing manager) that Miss W would not have consented to some offers of support from services.

5.7 Case notes record that, "*no contact was achievable at this time with either Miss W or the unidentified referrer.*" Adult Social Care (ASC) staff sent the information to Miss W's GP to consider the need for consent to refer her for possible exploration of her need for support to manage her excess alcohol consumption. Miss W's case was closed to ASC staff at this point. It seems that further contact was attempted by way of telephone by the GP or by the social worker. Given that information was available that she didn't have a telephone, it is concerning that a face-to-face visit wasn't attempted[17].

5.8 There have been some periods of delays in professional contacts with Miss W which at times were separated by periods of months. It was the family contact and escalation that resulted in the GP home visit in July 2019. They had expressed concerns for her welfare as she wouldn't allow them into her flat, but they could see she was in a neglected, unwashed state. The GP attended and arranged for an ambulance to take her, accompanied by family member(s), to Trafford General Hospital for an urgent mental health review by the Crisis Team. Notes from A&E described her as intoxicated though she denied drinking. Her daughter said that her mum had been drinking heavily and was heard talking to herself. The conclusion was she was experiencing a mental health relapse and was not taking her medication. It is unclear what happened next, but it seems that the expectation was that as she accepted support from her GP there was no need for further enquiries.

Evidence of Good Practice

5.9 It is difficult to find many examples of recorded good practice in relation to contact with and support for Miss W. Most organisations had very little contact with her, particularly in the last year of her life. The information available appears to show that she preferred not to have contact or to see herself as someone dependent on others. Whilst there are few examples of Miss W being contacted by agencies in that last year, there is one phrase that seems to be recorded more than once when she was offered support, "*I don't need anything, I am managing*".

[17] There is some contradictory information about her access to a telephone – whether she chose not to answer and/or she didn't have funds to top up her phone.

5.10 There is one example where the Irwell Valley Housing Tenancy Management Officer (TMO) visited Miss W following concerns raised by neighbours[18] about the condition of her flat, and he was persistent about getting in to see her. His approach of being helpful and reassuring, particularly in relation to ensuring her new boiler was working in November 2019, did result in in her agreeing to a social worker visiting and offering to arrange some support.

5.11 There is little detailed information recorded by her GP Practice, and many invitations to attend for check-ups were either ignored or not received by her, particularly as she sometimes didn't have access to a phone. She did, however, appear to accept some checkups from her GP, and on one occasion (July 2019) her GP attended her flat when called out by family members and was able to facilitate a brief admission to hospital where she had a mental health assessment and acceptance of a referral to the specialist Alcohol Liaison Team.

5.12 When Miss W was taken to Wythenshawe hospital in July 2020 there were several assessments undertaken to consider the viability of a range of health interventions. She was too ill to give consent about how she was to be treated. The one operation she did have was to relieve acute muscle pain. Hospital staff had discussions with family members about her future health prospects and what they believed she would choose given that interventions might keep her alive but with little prospect of 'having a life.' The family describe having expressed a wish to be led by clinicians.

Areas of practice where there were errors or where practice might have been done differently and led to better outcomes.

5.13 The most significant area where different practice could have led to a better outcome for Miss W was in late 2019/early 2020 when the Irwell Valley Housing manager appeared to have gained her trust and referred her for social work assessment. Joint work with a social worker was planned and Miss W had agreed to a further visit so that consideration could be made for a care and support plan to be put in place to support her. It is unclear why this didn't take place but by March 2020 Covid restrictions on face-to-face contacts began to affect service provision, and communication from the housing manager to the social worker seem not to have received any response.

5.14 On the 17th February 2020 Miss W elder sister contacted the GP surgery expressing her concerns. A GP made a home visit, but Miss W wouldn't let him in. They had a conversation through an open window, but Miss W declined any further intervention and the GP's assessment was that she had the mental capacity to make the decision not to see the GP.[19] It is unclear whether family members were contacted about this assessment and making a single assessment through an open window would not be

[19] www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/

regarded as demonstrating well informed professional practice. Onward referrals to other agencies were also not considered and would have been appropriate.

5.15 It is unclear how much note agencies took of the concerns raised by her family that she was confused, and her drinking was increasing which had led to a Vitamin B1 deficiency believed to have developed as a result of her excess alcohol intake. Miss W was prescribed Thiamine to treat her symptoms. There seems to have been no concerns from medical practitioners about the possible development of Wernicke Korsakoff and no record of a formal diagnosis of the syndrome, although her family identified and informed some agencies of her increasing levels of confusion in the last year of her life.

5.16 In 2020 Professor Michael Preston-Shoot and colleagues undertook an analysis of all SAR reports published between 2017-2019. The impact of harmful levels of alcohol consumption was seen as a factor in many of the SARs. Later in 2020 57 SARs were identified where the principal focus was a person with alcohol related concerns. Early trauma, self-neglect, and mental ill health, were seen as highly predictive factors for early death and/or significant harm. A further analysis of SARs completed in 2021-2023 confirms increasing numbers of SARs were identifying misuse of alcohol and self-neglect as major causes of early deaths.

5.17 The Review and analysis of published SARs identified that good protective practice could be identified as, "Thorough and robust care and support, risk and/or capacity assessments, routine monitoring for physical health, liaison with drug and alcohol teams and information sharing and good safeguarding systems involvement. More negative outcomes occurred where there was little/poor use of capacity assessments, absence of safeguarding referrals, mental health and alcohol services not working together, single agency activity, and no evidence of a 'think family' approach."

5.18 From the findings Professor Preston-Shoot and colleagues posited that, "From the individual's point of view, the problem as seen by the person is not the alcohol – it is likely to be a series of life problems. Alcohol is seen as the solution when the life problems of 'difference,' birth family disruptions, mental health and the way it is treated, unstable relationships, child dependency and removal, status, exploitation and self-neglect, finances, no work" become too overwhelming. Those people who had any knowledge of Miss W could have identified that she had experienced most of these life problems.

5.19 The Report concluded that, "*Attempting to change someone's behaviour without understanding its survival function will prove unsuccessful. This is very difficult for families who experience guilt and blame"*.

6. Conclusions

6.1 Miss W's early life have not been explored in great detail however it is clear from what is known that some risk factors for her were present in her child and early adulthood. She was said to have dyslexia, experienced mental health issues while at

school and her mother was described as having Schizophrenia. It seems family relationships broke down in her teens and she went to Scotland but had a difficult relationship with her partner at that time and had her very young child taken into care. Miss W experienced mental health admissions and is likely to have self-medicated by way of drug and alcohol misuse. She was identifiable to others as an adult with care and support needs and therefore likely to be vulnerable, and concerns were raised by family around possible financial exploitation.

6.2 In relation to record keeping-Trafford Council's own analysis of this contact is that it is not clear from the agency records why there was no assessment undertaken at the point of the contact, in December 2018. The records also show no explicit consideration of the duty the service had to undertake proportionate enquiries, including whether the threshold was met for a safeguarding response under the Care Act 2014 which would have initiated the consideration of a multi-agency protection plan. Whilst on occasion Miss W refused to engage with professionals there is no evidence that there were any plans to negotiate agreement about what she would agree to or to actions she would want taken if she was unable to give consent due to illness. There is evidence in records that she had consented to have professional involvement when she could understand the benefits.

6.3 For someone experiencing long standing difficulties the impact of Covid and its restrictions on her, family, friends, and health and care organisations may have normalised her isolation. However, this also added increased risks to personal, financial and accommodation deterioration, and possibly abuse with a greater reliance on alcohol, which can have initial happy effects, leading to low mood and potentially 'can't get through the day' dependency and increasingly serious physical health conditions.[20]

6.4 Staff from a number of organisations with responsibilities for identifying adults with unmet care and support needs and increasingly risky, self-neglecting and harmful behaviours were restricted from face-to-face contacts with adults during Covid lockdowns. For some like Miss W who expressed her reluctance to have any support this may have been welcomed but it also provided an environment where she could fall victim to exploitation, drink to levels that caused confusion, weight loss, poor

[20] www.gov.uk/government/publications/alcohol-consumption-and-harm-during-the-covid-19-pandemic.

"The upward trend in total alcohol specific deaths was brought about by increases in deaths from alcoholic liver disease. Alcoholic liver deaths accounted for 80.3% of total alcohol specific deaths in 2020 and saw a 20.8% increase between 2019 and 2020. From July 2020 onwards, rates of alcoholic liver disease deaths were significantly and consistently higher than baseline. Data from previous years show a rapid acceleration in deaths from alcoholic liver disease during the year of the pandemic, beyond that of the pre-existing upward trend."

personal care and refusal of any contact with family and others concerned about her[21].

6.5 This case echo's themes seen nationally indicating that learning is not being embedded as we continue to see cases that have self-neglect at their heart; where the misuse of alcohol and spikes in the severity of mental illness have not been recognised, and the assumption of capacity is not critically assessed. This is particularly important in relation to understanding what the consequences of certain behaviours might have on wellbeing and safety. Evidence of identifying supportive practice that is personal to the 'at risk' person, needs to be built into regular staff supervisions and agency audits.

6.6 In terms of missed opportunities there is some evidence that if Miss W experienced a specific kindness/offer of practical help as experienced in the changing of a lightbulb and the fixing of her heating system, she was willing to have contact with professional staff. There is a requirement for professional staff to be respectively curious about traumatic early life events and to persist in building trust and engaging with concerned families and friends without breaching the right of the adult at risk to 'own' their confidential information about their need for care and support. There appears to have been a lack of professional curiosity and limited evidence from some agencies that they had tried to effectively engage Miss W given the circumstances and ongoing reports of risk.

7. Recommendations

1. TSSP and its partners should review existing self-neglect guidance and multi-agency risk management processes, in the light of the learning from this review, remedy gaps or omissions and include stronger focus on family engagement.

2. TSSP should audit the use of its guidance on self-neglect and multi-agency risk management processes by agencies across the Partnership and take measures to strengthen practice through training, guidance or supervisory practice where indicated.

3. Adult Social Care should audit decision-making on, and outcomes of self-neglect adult safeguarding concerns referred under section 42(1) Care Act 2014, to seek assurance that risks are being effectively addressed, managed and reduced.

4. TSSP to seek an assurance about the impact of training and supervision on the quality and impact of frontline practise in in cases of neglect.

5. TSSP should seek assurance from Greater Manchester Mental Health Service and substance misuse (including alcohol) service providers on how they are working, individually and collaboratively, in cases of self-neglect that involve mental ill-health and substance misuse

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