Waltham Forest
Safeguarding Adults Board

Safeguarding Adults Review on Andrew

Lead Reviewers:
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Submitted to the SAB: June 2017

Why this case was chosen to be reviewed

The One Panel, (the panel in Waltham Forest that makes recommendations on whether the criteria for statutory reviews or other learning events has been met for, Serious Case Reviews, Safeguarding Adult Reviews (SARs) and/or Domestic Homicide Reviews) on behalf of the Waltham Forest Safeguarding Adult Board (SAB) considered the case of Andrew (not his real name) in September 2016 and made a recommendation to the SAB independent chair that the criteria was met for a Safeguarding Adult Review as set out in the Care Act 2014. The SAB chair agreed. The case involved the death of Andrew from alcohol related liver disease. In the last year of his life Andrew had become homeless and he had been living in supported accommodation. The responses of a range of partners had often been well intentioned but not joined up or particularly effective; however, it is the opinion of the reviewers and the review team that working differently would not have prevented Andrew from dying.

There was a view that the case represented many other cases in the Borough and across London in terms of the challenges of meeting the care and support needs of someone with long term alcohol dependency who is self-neglecting. The case offered much useful learning about systemic issues related to multi agency and cross sector support of adults with serious health issues and ongoing alcohol dependency.

Succinct summary of case

Andrew was an independent and private man. He had long standing alcohol dependency, which he had managed for a number of years, and allowed him to work and retain a tenancy until the later part of 2014. The drinking eventually led to significant physical and emotional health challenges in the last year of his life. At this point he had lost his tenancy and was living in supported housing at Wardley Lodge provided by SHP organisation.

Andrew was supported by professionals at different times, the most consistent being from Wardley Lodge. Andrew preferred practical support to any meaningful emotional engagement. He also had a long standing relationship with a drug and alcohol worker; which stemmed from an outreach service, which was decommissioned during 2016. Support was focussed on harm reduction and practical targets. Andrew was firmly of the belief that he could stop drinking himself when the time was right.

In the spring of 2015 a fellow resident and close friend of Andrew's died suddenly and unexpectedly. This death had a profound impact on Andrew's emotional well-being and marks the onset of a steady decline in his physical and emotional well-being and his eventual death from alcohol related conditions arising from his self-neglect. During the last year of his life professionals tried to gain support for Andrew, amidst what appears to be a growing sense of helplessness. He was referred between services for his emotional well-being, self-neglect and alcohol dependency but none were able to successfully work with him to redirect his addiction or behaviours on a voluntary basis. He was always considered to have mental capacity.

Andrew remained living in the community at Wardley Lodge, latterly medically supported by a local GP until he died in hospital in February 2016 aged 39 years from alcohol related illnesses.

Family composition

Andrew lived alone in supported accommodation. He had a son who he saw occasionally but not for some time before his death. He remained in limited contact with his mother and had more contact with his sister but again not for some time before his death.

Review timeframe

The period being reviewed for this SAR covers the time that Andrew moved into supported accommodation through SHP at the beginning of 2015 through to his death in February 2016.

Organisational learning and improvement

Statutory guidance to support the Care Act 2014 states that:
"The SAB should be primarily concerned with weighing up what type of 'review process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases". (Department of Health [DoH] 1 14:135)

The One Panel identified that the review of this case held the potential to shed light on particular areas of practice that are not peculiar to this case and related to supporting self-neglecting adults with alcohol dependency who are near the end of life.

The following broad research questions were agreed:

1. What can we learn about how practitioners assess the capacity of people who self-neglect and use substances?

2. What can we learn from this case about how practitioners work together when trying to support people who use substances, who do not want to engage with support services?

The use of research questions in a *Learning Together* systems review is equivalent to Terms of Reference. The research questions identify the key lines of enquiry that the SAB want the review to pursue and are framed in such a way that make them applicable to casework more generally, as is the nature of systems findings.

Methodology

Statutory guidance requires SARs to be conducted in line with six identified in the Care Act 2014 and the principles below (DoH, Chapter 14: p 138):

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined

- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- 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
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively

It also gives SABs discretion to choose a review methodology that suits particular circumstance:

"The process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected". (DoH, 14:141)

Waltham Forest SAB commissioned the SCIE *Learning Together* systems model (Fish, Munro & Bairstow 2010). It wanted the review process to be based around a one-day Learning Together workshop. This took place over 2 half days and engaged the front line practitioners and managers to generate qualitative data needed to inform the review process and was enriched by detailed conversations. Details of what the review entailed are contained in the appendix of this report.

A Learning Together review process is based on key principles:

Avoid hindsight bias: understand what it was like for workers and managers who were working with the family at the time. In particular, explore what sense they were making of the case, and the contributory factors which were influencing their practice at the time.

Provide adequate explanations: appraise and explain decisions, actions and inactions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it.

Move from individual instance to the general significance: provide a 'window on the system' that illuminates what supports and what hinders the reliability of the multi-agency safeguarding system.

Produce findings and questions for the Board to consider: Pre-set recommendations may be suitable for problems for which the solutions are known, but are less helpful for puzzles that present more difficult issues.

Analytical rigour: use qualitative research techniques to underpin rigour and reliability.

Details of the model and this process are available on the SCIE website www.scie.org.uk

Proportionality
Deciding on a proportionate review process took into account previous reviews and learning, locally and nationally; focusing on the learning from this case that had not already been explored.

Reviewing expertise and independence

The SAR has been led by two people independent of the case under review. Caroline Budden is an externally commissioned independent reviewer who has been trained and is under-going her accreditation and Suzanne Elwick, Head of Strategic Partnerships, LBWF is accredited to carry out SCIE reviews. Neither have had any previous involvement with the case. Caroline Budden has no previous or pertinent relationship with Waltham Forest Council or its partners.

The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

Methodological comment and limitations

Participation of professionals

Key practitioners and managers involved with the case were able to participate in the Learning Together workshop. The Lead Reviewers were also able to talk separately with key professionals from the case group, to understand their 'story' and clarify factual information and to meet with senior agency managers who subsequently formed the Review Team. Although the GP did not attend the workshop, she was able to contribute through a conversation with the Lead Reviewers.

Perspectives of the family members

Andrew's mother and sister were invited to be involved in the review process, however they did not engage with the Reviewers. This is understandable in view of the time between his death and the review.

Structure of the report

First the Appraisal of Practice section provides an overview of what happened in this case. This clarifies the view of the Review Team about the timeliness and effectiveness of the help given to Andrew, including where practice was above and below expected standards. Secondly, a short transition section reiterates the ways in which features of this particular case are common to the way professionals work with other adults and therefor provides useful organisational learning to underpin improvement and continuous learning. Thirdly the Findings form the main body of the report.

Statutory guidance requires that SAR reports "provide a sound analysis of what happened in the case, and why, and what needs to happen in order to prevent a reoccurrence, if possible (DoH, 14:149);

The Findings

Brief case summary and Findings

The period being reviewed for this SAR covers the time that Andrew moved in to accommodation through the SHP at the beginning of 2015 through to his sad death in February 2016 from alcohol related illnesses.

Duration	Detail
January 2015-Feb 2016	Andrew living at Wardley Lodge
April 2015	Death of friend who is fellow resident at Wardley Lodge
April - June	Decline in Andrew's well-being. Inappropriate behaviour by Andrew and his deteriorating physical health leading to his first exploratory medical tests
June 2016	The GP1 is closed by CQC. Patients are advised and a decision is made to disperse the patient list and for those patients that remain on the GP1 list beyond 19th June 2016 to be merged to another GP list.
September - November	Andrew's street drinking continues, resulting in significant ongoing deterioration in Andrew's physical health and diagnosis of cirrhosis. Andrew self-discharges from hospital.
November	Andrew registers with new GP2, who requests discharge summaries from the hospital as GP has noted that summaries may have been sent to the previous GP1.Wardley Lodge make referrals to Lifeline and Mental Health Services and feel isolated in attempts to support Andrew
November	Andrew disengages with keyworker at Wardley Lodge, and his self-neglect escalates
November – January 2016	Andrew's physical and emotional well-being deteriorates, professional concerns escalate leading to referrals for additional assessments and support. Andrew attends GP 2 for physical health issues associated with his alcohol dependency
January 2016	Significant deterioration in Andrew's physical health and emotional well-being. Referrals and attempts at further assessment are not successful. Professionals consider Andrew to be competent and to have mental capacity.
February 23 – 24th 2016	Andrew admitted to hospital very unwell with alcoholic cirrhosis and associated varices bleeds. His condition worsens. He dies from variceal bleeding, portal hypertension and decompensated liver failure at 0758hrs

	on 24th February.

Appraisal of professional practice in this case:

Introduction

At the heart of this case was Andrew, a man who we believe had experienced some form of emotional distress in his past which possibly led to him using alcohol to cope/self-medicate. Many people tried to support Andrew and help him reduce his drinking and make different choices about his life. Unfortunately, Andrew chose not to take up the support. The practitioners worked in silos and didn't work as a team around Andrew which impacted on the support they could offer him. Towards the end of his life these offers of help were then misplaced and the shift was not made by practitioners from offering help to reduce the drinking to help with end of life care, when it was apparent that Andrew was nearing death.

The practice

The SHP appropriately provided Andrew with accommodation after he lost his long term tenancy. This marked a turning point in his life with the loss of independence that arose from with his changed homeless status. Wardley Lodge correctly identified his key needs and challenges to address debt and his alcohol dependency. Wardley Lodge recognised that Andrew struggled in the first 'settling in' months and tried to provide support through a key worker. The worker recognised that Andrew did not want to engage in emotional problem solving and focussed target setting conversations through playing chess with Andrew. This was a good attempt at fostering engagement.

The drug and alcohol outreach service key worker had been involved with Andrew for quite some time before Andrew moved to Wardley Lodge and was able to get alongside him when he met informally in local community settings. The flexible provision of this service was able to respond positively to Andrew and his needs in relation to alcohol abuse by providing easy opportunities for engagement. However, street outreach has its limitations in terms of the depth of work possible when engaging with someone in this way

Professionals were well intentioned, committed to wanting to help Andrew, but at times this was in isolation, reflecting a lack of integrated working. This was evidenced in the workshop when populating the timeline of activity for Andrew, when it was clear to the review team that members of the case group, although working with him concurrently, were unaware of each other's contribution or worries. **This is explored more in the Findings.**

In April 2015 a fellow resident at WL died, and this had a significant impact on Andrew raising issues of his own mortality as well as possible issues of unresolved grief. His vulnerability increased. It was a downhill turning point. It was also a time when his physical health began to further deteriorate. It was clear to the review team that Wardley Lodge staff were also impacted

by the death of the resident. It is good policy and practice that the organisation provided supervision and support to help staff to manage their own grief while supporting clients. This good practice helped them to observe and support Andrew. The Review Team found this period to be a critical turning point, not only for Andrew, but also professionals as Andrew's growing sense of fatality seemed to be mirrored in a growing sense of professional isolation and helplessness. From April Andrew increasingly disengaged from Wardley Lodge and drug and alcohol services and only engaged in incident instigated interaction with health providers; most commonly the hospital. The review team saw a pattern of poor inter-agency working evidenced through increasing silo working by professionals. Professionals responded to their own increasing concerns about Andrew's health and wellbeing by referring on to others rather than by communicating with others who they knew were working with Andrew to share concerns and develop a plan of support and intervention.

As time goes on the hospital becomes the place of last resort that Andrew goes to for urgent intervention. It provided appropriate emergency care and arranged for follow up tests for diagnostic health work to understand the cause of Andrew's increasingly worrying health symptoms and the impact of his chaotic lifestyle. It was good practice that theWardley Lodge key worker tried to accompany Andrew's to have the further tests. Discharge notes were sent to the GP 1 for his records in line with expected policy, but the GP practice had closed in June 2016, with some professionals, namely Wardley Lodge and WX Hospital seemingly unaware. It is not clear where the communication fell short as the process of GP closures includes the communication with stakeholders regarding any closures. Staff were dependent on patients telling them of any change to their GP. In the case where the patient has capacity, but for whatever reasons does not inform the organisation supporting them in the community, and where staff are reliant on patients telling them of any change to their GP, such a system presents with gaps for services users such as Andrew and is not a system that supports good practice. The review team observed that throughout there was much well intended intervention from professionals, but Andrew required professional coordination with good interagency communication and joint working which unfortunately was not the case. There were many missed opportunities for cohesive multi-agency working by professionals in the last 9 months of Andrew's life. Presently there is no formal process in policy and practice for working with adults below the safeguarding processes and this impacted on the support Andrew received. **These issues are explored further in Finding 1.**

The decommissioning of the drug and alcohol service during the summer of 2015 had a significant impact on Andrew who was not motivated to make or attend pre-arranged appointments to address his addiction. The Outreach service was an example of a flexible service with the user at its heart, which had provided an opportunity to engage with him in the community to build a relationship and set harm reduction targets. This was not part of the contract for the newly commissioned service.

The review team noted a perceived negative professional hierarchy amongst some professionals. This resulted in the outreach workers rarely being invited to case conference meetings at Wardley Lodge. The outreach workers felt there was a view from SHP workers that the information that they held and the importance of the relationships they established were not

of sufficient value. This led to poor practice as information was not shared and there was no opportunity for joint care planning.

From the summer onwards Andrew's health was on a trajectory of spiralling decline. Wardley Lodge remained a constant throughout and tried unsuccessfully, on more than one occasion to refer him to the Access team for a mental health assessment. Some of the review team were surprised that the Access team followed up the referrals by phone. Andrew was not visited for the purpose of an assessment which the review team were advised was usual practice. Good practice would have been to see Andrew to attempt an assessment, providing an opportunity to speak with other professionals and further multi-agency joint working. Although SHP workers were exasperated that their attempts to secure further support for Andrew were not successful they did not arrange a professionals meeting to identify a lead worker, share concerns or develop a plan of support and care which was what Andrew required. It would be good practice to arrange a multi-agency meeting to share information and understand what people were worried about and consider possible solutions and interventions available for an adult with capacity who is self-neglecting. **This practice is not embedded in adult services and is discussed further in Finding 1**

Towards the end of 2015, Andrew was very unwell, disengaged from the support offered by Wardley Lodge and did not engage with the new drug and alcohol service. His need for medical support had significantly increased. At this point it would have been appropriate and good practice to make a safeguarding referral to adult social care. Support staff at Wardley Lodge discussed making a safeguarding referral, but decided that they would if the situation declined further. A referral was never made.

Wardley Lodge had made significant efforts to get Andrew registered with a new GP and worked consistently with Andrew to get him to attend the surgery. GP 2 became involved after he attended hospital for urgent care. The GP was very worried about his condition. She wanted to help and build a relationship with Andrew, but could see that he was very ill. She showed compassion and care in her persistence to engage him. The review team were critical of her decision to prescribe community detoxification drugs without a package of support in place first as this is poor practice and outside policy and guidance. Instead good practice would have been to work with Andrew about his impending death. In the last two months professionals failed to 'get a grip' of the case and continued with their attempts to refer Andrew on to others for assessment and possible treatment. There was no lead professional taking ownership of the case to develop a support plan which was what Andrew needed.

In January 2016, it would have been clear to professionals with an experience of working with people who misuse alcohol that Andrew was now terminally ill. Professionals continued to try to assess and treat his physical condition and encouraged him to stop drinking. He clearly was not going to, despite worsening health. The review team is critical of the unwillingness of any professionals to talk to Andrew frankly about his approaching death. It would have been good practice to support Andrew in understanding his impending death and help him to prepare for it and to die with dignity and in line with end of life policies and procedures. **This is explored further in Finding 4**

In what ways does this case provide a useful window on our systems?

This case has several elements which are common to other cases involving adults who have mental capacity but may still be at risk of self-neglect. Cases of this nature can be particularly challenging for professionals if the adult chooses not to engage with the support being offered by professionals to reduce harm and improve their life outcomes and instead continues to make what could be considered “unwise decisions or choices”.

This can lead to professionals struggling to address the risks effectively and leading to a sense of helplessness which is emotionally demanding and leaves professionals feeling powerless and frustrated.

The findings in this SAR address the research questions identified at the start in relation to:

1. What can we learn about how practitioners assessing the capacity of people who self-neglect and use substances?

2. What can we learn from this case about how practitioners work together when trying to support people who use substances, who do not want to engage with support services?

The four findings address the issues of how adult services work with adults below the threshold of safeguarding, the lack of shared understanding of adult safeguarding, how services respond to adults with alcohol and emotional distress and the issue of end of life care for adults dying as a result of alcohol misuse.

Summary of findings

1	**Finding1** Outside of the safeguarding framework, there are limited mechanisms, particularly when adult social care is not involved to bring together staff from across agencies, involving high risks, to plan and review work, increasing the chances of interventions being less effective. (Management system issue)
2	**Finding 2** It is not routine or shared practice to accept that chronic alcohol misuse is a form of self-neglect and when this becomes a safeguarding issue, particularly when the person has capacity. This directly affects the response by professionals and the support that is offered and provided to service users. (Management system issue)
3	**Finding 3** People with alcohol dependency and emotional distress are left with limited options of help because services are not equipped or commissioned to provide support for both issues together which ignores the interconnected nature of people’s dependency and emotional distress. (Management system issue)
4	**Finding 4**

	There is no widely used care pathway, or allocation of role or responsibility for the palliative care of self-neglecting adults who are terminally ill, as a consequence of their addictions. This leaves frontline workers trying and often not succeeding to respond appropriately, increasing the risks that people with alcohol dependencies die with little support or dignity. (Management system issue)

Finding 1

Outside of the safeguarding framework, there are limited mechanisms, particularly when adult social care is not involved to bring together staff from across agencies, involving high risks, to plan and review work, increasing the chances of interventions being less effective (management system issue)

Introduction

Supporting adults who self-neglect, but who have capacity, brings challenges to a range of professionals. A key challenge for services is the chronic nature of self-neglect, cases are long standing and often not characterised by single abusive events that lend themselves to a traditional safeguarding enquiry. Formal opportunities for information sharing and joint working are limited due to a lack of accepted practice of joint working outside of the formal framework of safeguarding as defined in the Care Act 2014 and the Pan London Safeguarding Adults Multi Agency Procedures. In adults there is no guidance on how to work in the space outside formal process, how and when to share information in line with data protection that is concerning professionals but would not yet meet the threshold for safeguarding. Practitioners lack confidence, particularly when adult social care is not involved, supporting these cases where the level of concern falls below that for safeguarding. There is no absolute description in guidance about the role of a lead professional and there is no concept of team around a family or team around an adult as practiced regularly in children's services.

Safeguarding processes provide a statutory framework as a response where there are concerns of risk to adults, who due to the nature of their vulnerabilities, are less able to protect themselves from abuse or neglect. Historically, safeguarding enquiries were focussed on those situations where an adult was being abused or neglected by individuals or organisations. The Care Act 2014, introduced additional categories of self-neglect. This has widened the reach of safeguarding to cover a range of issues that have a high level of risk, often with service users who are reluctant to engage with professionals, this includes hoarding and adults who are vulnerable through alcohol or drug misuse.

How did these issues manifest themselves in this case?

There were a number of different professionals working with Andrew during the last 18 months of his life, however they did not come together to share information or plan for his care and support.

This review has highlighted the difficulties encountered by 'silo working' and situations where workers are not confident about whether they can or should engage others in collective working

to develop a 'team around the client' rather than making a referral to other agencies. It appeared to the Review Team that all agencies became isolated in their attempts to support Andrew and as the sense of professional helplessness increased then the default position became that of referring on to others.

In the last 12 months of Andrew's life there was a growing pattern of agencies making referrals to other agencies which did not result in productive intervention. It was clear that at all times the key workers were compassionate in their approach and sincere in their ambition to gain additional support, but it was to no effect. It is recognised that this situation was compounded by Andrew's strong sense of privacy, need for independence and a determination to only do what he wanted to do and his own way.

Services were increasingly worried about Andrew. However, there was little regular communication between the organisations outside of referrals, instead they worked in isolation to try and provide support to him. When workers became increasingly worried they made a referral to another organisation for an assessment e.g. by the mental health team. This pattern of professional response continued throughout, including with GP2. She also wanted 'to help' and referred Andrew to drug and alcohol services as well as the mental health team. Although professional had growing concerns they appear to have not understood the escalating risk and despite the cycle of onward referrals this did not include adult social care who would have been looked to as the coordinating agency to bring others together to share information. The perceived professional hierarchy experienced and described by some professionals, particularly those with roles that had community based engagement with Andrew, further led to the sense of disempowerment and the idea of onward referral being an end in itself, rather than a proactive attempt to bring professionals together.

The case group and review team identified a need to know when and how they could arrange meetings / conferences to bring professionals together to support the sharing of information and informed and collective care planning, particularly in cases where adults with capacity did not want help. This was particularly relevant when adult social care was not involved and not taking the lead. They spoke of isolation and expressed helplessness, a difficult professional emotion to acknowledge for workers who want to 'help make things better'. The review team saw a significant depth of compassion and caring about Andrew from across organisations but this was not evident in the practice outcomes. Poor collaborative multi-agency working led to missed opportunities to share information and effective planning.

How do we know that it is not a one-off but an underlying issue?

Members of the review team and case group were able to identify many service users similar to Andrew, presenting with high risk but a reluctance to engage with services. Andrew's case provides an opportunity to pause and consider if onward referral is the best way forward or whether professional support and collaborative working would bring about better outcomes.

In the children's safeguarding arena, the concept of professional meetings, team around the client and the identification of a lead practitioner is well established. The Review Team did not find evidence of this practice amongst professionals outside of adult social care working with

vulnerable adults which is unsurprising due to the lack of guidance in this area. Given the complex and diverse nature of self-neglect, responses by a range of organisations are likely to be more effective than a single agency response, however formal guidance is limited. A robust risk assessment, preferably multi-agency, that includes the views of the adult and their personal network is central to good planning (London Multi- Agency Adult Safeguarding Policies and Procedures.2015). There is no formal guidance to support professionals in this type of approach or the allocation of a lead practitioner.

All participants of the case group expressed a wish to share information and have opportunities for joint planning, but were not familiar with how to make this happen and were concerned about breaching confidentiality and going against Andrew's stated wishes for privacy and independence. Some practitioners also described the same challenges with what could be considered other forms of health related self-neglect.

How common and widespread in this pattern?

Case group and review team members who were from different organisations and worked in numerous boroughs identified silo working as a challenge in other cases, demonstrating that the practice of multi-agency joint working below the safeguarding threshold was common and to some extent widespread. We have no specific data to evidence how widespread the challenge is but we are aware that from other statutory reviews this has also been identified as an issue (Richmond SAR December 2016). Although information sharing protocols exist, services consider these to be aligned to safeguarding. Professionals are not confident about when and how to share information outside of a safeguarding enquiry.

Discussion in the workshops highlighted that there is not a shared understanding of when and how it is appropriate to call professional meetings to share concerns about adults presenting as high risk who fall outside the traditional safeguarding criteria. There were some examples given of good interagency liaison in some cases, but members of the workshop were of the view that this was down to the tenacity of individual workers and not embedded in collective practice or supported by the policy framework.

What are the implications for the reliability of the system?

Managing cases where there are high risks is difficult intellectually and emotionally, it is also lonely and anxiety provoking. A safe system requires all professionals to be competent and confident in their role and responsibilities. Workers need to be able to make informed decisions to support effective care planning in the best interests of clients in the most challenging of circumstances. This is more likely to happen in a system where workers know when and how they can share information and are confident that other professionals will come together to develop the best client centred care plan possible.

Silo working, however well intentioned, does not support informed care planning or clarity as to roles and responsibilities. Without effective and recognised mechanisms in place for agencies to

share information and jointly manage risk there is a likelihood of poorer outcomes for clients and emotional exhaustion of staff.

Finding 1
Outside of the safeguarding framework, there are limited mechanisms that bring together staff from across agencies to plan and review their work in cases involving high risks, to plan and review work, increasing the chances of interventions being less effective (management system issue)

What would a safe system look like and what impact does this pattern have on safe functioning?
The complex nature of multi-agency support of adult service users requires a variety of mechanisms to manage risk across services to ensure that the voice of the service user remains core to care and risk management planning and the supporting of front line practitioners. Formal safeguarding processes provide this for those cases meeting the safeguarding criteria. There are many other situations where high risk is being managed by services in isolation that fall outside the safeguarding criteria; these situations require an alternative system wide process.

Questions for the board to consider

1. Does the SAB have a role to play in promoting and supporting a shared understanding of when it is appropriate for there to be information sharing to manage risk and improve outcomes; particularly in cases of drugs/alcohol and mental health?
2. Do SAB members have a good understanding of the role of the lead professional and the opportunities to call professional meetings, particularly when adult social care is not involved?
3. What mechanisms does the Board require to ensure that adults at high risk are appropriately assessed and supported by agencies working together?

Finding 2

It is not routine or shared practice to accept that chronic alcohol misuse is a form of self-neglect and when it becomes a safeguarding issue, particularly when the person has capacity. This directly affects the response by professionals and the support that is offered and provided to service users. (management system issue)

Introduction

Self-neglect involves any failure by an adult to take care of him or herself, which causes or is reasonably likely to cause serious physical, mental or emotional harm, or substantial loss of assets (LBWF Multi-Agency Self Neglect Policy, December 2016)

The Care Act 2014 statutory guidance includes self-neglect in the categories of abuse or neglect relevant to safeguarding adults with care and support needs and includes reference to substance misuse which includes alcohol and drugs. In some circumstances, where there is a serious risk to the health and wellbeing of an individual, it may be appropriate to raise self-neglect as a safeguarding concern. This guidance is helpful in flagging self-neglect as safeguarding. However guidance also advises that interventions on self-neglect are **usually** more appropriate under the parts of the Care Act dealing with assessment, planning, information and advice, and prevention.

The guidance is not clear about when self-neglect is safeguarding and therefore professionals are not clear. Chronic alcohol misuse is not always readily seen by all professionals as self-neglect. However if we apply the definition above it is clear chronic alcohol misuse is self-neglect and finding the right way to support people is further complicated if the person misusing alcohol is deemed to have capacity.

The Mental Capacity Act 2005 is very clear that adults with mental capacity have the right to make their own decisions. Capacity should be assumed until there is a clear assessment that confirms a lack of capacity.

Guidance on risk assessment and management from the DoH highlights the value of service users being supported to take risks and refers to risks being 'a nature and healthy part of independent living'. Professionals working with adults would support the values implicit in this guidance; however the reality of working with people with capacity who display risk taking behaviour is very challenging. Professionals find themselves in a dilemma between valuing people's human rights to make their own decisions, recognising that people's behaviour is putting the life at risk and being aware of their professional duty around safeguarding.

How did the issue manifest in this case?

Andrew was an independent and private man. He had a long history of alcohol abuse. Andrew appeared to have experienced some form of emotional distress in his past that may have led to his alcohol misuse.

From the reviewer analysis it is clear to see that Andrew was self-neglecting through his alcohol use. This had led to him losing his job and becoming homeless. Andrew's alcohol use dominated his life and his daily living and life choices were made with alcohol at the fore. Andrew's physical health was significantly impacted by his alcohol use and during the time period of the review it is clear to see how his increased alcohol use led to his deteriorating health to the point of dying.

Andrew declined numerous continual offers of support to address his alcohol use. He told professionals he knew the consequences of his continued drinking and all professionals believed he had capacity to understand the implications of his decisions.

In late 2015 Andrew's physical health significantly deteriorated, his attention to his personal appearance declined, his drinking and anti-social behaviour increased. Andrew declined medical attention, support from alcohol services, support from Wardley Lodge and did not want to engage with mental health service. Health professionals and others were clear that he would not be appropriate to section under the Mental Health Act and all seemed to be at a loss as to what to do. More than one professional described Andrew as 'a man who was slowly committing suicide'. The question repeatedly arising in this review being 'how do you help someone who does not seem to want to be helped'?

The review team identified that at this point a safeguarding referral would have been appropriate due to the level of self-neglect, the obvious impact on his physical health, and the presentation of his emotional well-being. A safeguarding referral was discussed by some professionals but no safeguarding referral was made.

How do we know that it is not a one off but an underlying issue?

The review team heard from a number of professionals making reference to other cases that were similar where adults were misusing alcohol, drugs, or had eating disorders, failing to follow up medical needs etc. which all described behaviours that could be named as self-neglect but were so often not. Feedback from review and case group members confirmed that professionals were often working with people with capacity who make 'unwise decisions' and whose behaviours could be described as self-neglect.

When we discussed together Andrew's decline it became clear to the review team and case group that what we were describing was self-neglect but this was not always clear to them at the time. The review team and case group spoke about how it is not routine or shared practice to accept that chronic alcohol misuse is a form of self-neglect or when it becomes a safeguarding issue, particularly when the person has capacity. This directly affects the response by professionals and the support that is offered and provided to service users.

The review team and case group spoke about how it was clear and easier to identify self-neglect if a person was hoarding than chronic alcohol misuse. Self-neglect through hoarding was often easier to see and easier to name. The effects of chronic alcohol use will be seen over a long time period and can be less tangible and some emotional wellbeing and daily living issues can be more difficult to solely relate to the alcohol use.

Case group and review team members reflected further that there was not a shared understanding of or clear guidance provided for when self-neglect became a safeguarding issue.

Those who had taken on roles that were about helping people understandably struggled with the reality at times of being able to do very little. The review team witnessed a universal sense of professional frustration that was caught up in the confusion of not having a universal understanding of chronic alcohol use being self-neglect, when that tips into adult safeguarding and therefore when is it appropriate to act outside of the person's stated wishes.

How common and widespread in this problem?

The Care Act does recognise the dilemma posed to staff in these situations, but unfortunately does not provide further guidance. It states' that if the adult has the capacity to make decisions in this area of their life and decline assistance, this can limit the intervention that organisations can make'

Research into cases of self-neglect by Preston Shoot and Braye (SCIE Fact Sheet 46) acknowledges the particular difficulties for front line staff who are working with adults who are neglecting themselves and who are reluctant to engage with staff.

It is not surprising that staff find it difficult to be clear about when self-neglect due to chronic alcohol use becomes safeguarding as there is much disagreement in the adult safeguarding world itself. Public opinion reflects these dilemmas where in cases where practitioners have intervened they have been criticised for going against someone's human rights to choose and also criticised for not intervening and something terrible happening to someone.

A recent community care article and the comments this prompted by different professionals illustrates this http://www.communitycare.co.uk/2017/04/03/call-tougher-adult-safeguarding-standards-mans-murder/?cmpid=NLC%7CSCSC%7CSCDDB-20170404

The article is about a SAR review completed on a similar case where a man was a chronic alcohol user and declined the consistent and persistent support that was offered to him. He died when he was killed by a fellow drinker. The SAR panel urged authorities to consider how adult safeguarding practices could be better aligned with those that exist within child protection services going forward.

This prompted other professionals to highlight that adult safeguarding is different because adults with capacity have the right to make their own decisions and there is a fundamental difference between child and adult safeguarding

Evidence from other SAR would suggest that the practice of professional meetings, or multi-agency meetings around the client are not embedded practice in adult services and works against professionals being able to share their concerns and together devise a plan to support the client.

The Mental Capacity Act advises you need to wait until a person is sober before you think about capacity. However, when a person is a chronic alcohol user it could be argued that they are never sober. More so that their ability to reason about whether they want to stop drinking is

significantly impaired due to the addictive nature of their alcohol use. Therefore, is someone who is a chronic alcohol user ever in a space where their addiction is not impacting on their ability to reason.

It is also important to recognise the role of 'making safeguarding personal (MSP)' which is a sector led initiative which aims to develop an outcomes focus to safeguarding work, and engage with people about the outcomes they want and then ascertaining the extent to which those outcomes were realised at the end. https://www.adass.org.uk/making-safeguarding-personal-publications. If MSP is embedded into all practice with adults the issue of individual choice will be central to assessments.

What are the implications for the reliability of the system?

The system is presently unreliable due to the confusion and lack of clarity for practitioners in regard to when chronic alcohol misuse is self-neglect and when that becomes a safeguarding issue. This leads to an inconsistent approach by practitioners and service users not always receiving the response they require. The system itself has not yet recognised this complexity and present guidance and Pan London procedures are out of date with the reality of the issues that practitioners are facing regularly in their daily practice.

Finding 2
It is not routine or shared practice to accept that chronic alcohol misuse is a form of self-neglect and when it becomes a safeguarding issue, particularly when the person has capacity. This directly affects the response by professionals and the support that is offered and provided to service users

What would a safe system look like and what impact does this pattern have on safe functioning?

It is particularly emotionally demanding and stressful for professionals working with adults who have capacity, who are self-neglecting and continuing to make 'unwise decisions' and declining support.

The adult safeguarding system does not presently enable practitioners to clearly and easily identify adult safeguarding concerns when a person is self-neglecting and a chronic alcohol user which directly affects the response service users receive from practitioners.

Questions for the board to consider

1. Does the picture of confusion resonate with the Board?
2. What is the board's view of the understanding of chronic alcohol use, self-neglect and the ability to reason and have capacity?
3. What can the board do to address the systematic adult safeguarding issues relating to identification and support of adults in need of safeguarding?

Finding 3

People with alcohol dependency and emotional distress are left with limited options because services are not equipped or commissioned to provide support for both issues together which ignores the interconnected nature of people's dependency and emotional distress. (Management system issue)

Introduction

In general services are commissioned and organised to deliver support for either one issue or the other and rarely together. The challenge is to find a way to deliver support for both issues at once. Instead people usually fall between the two services where they cannot receive support for their mental health until they have addressed their addiction and they do not feel able to address their addiction because of the stress of their mental health. Their overlapping needs mean this group is in most need of specialised services but often do not receive adequate support.

How did it manifest in this case

Andrew had a long history of alcohol dependency and from his time living at Wardley Lodge staff observed his emotional distress which they believe may have been related to a significant bereavement. This distress became significantly worse as a result of the death of his friend and fellow lodger in April 2016. Following this death Andrew's response was to drink even more, perhaps in a way to self-medicate as his way of dealing with his grief. Andrew declined support offered by Wardley Lodge to help him with his grief. Andrew become more emotionally distressed and his drinking increased creating a vicious circle.

Staff at Wardley Lodge became concerned about Andrew when this continued and referred him to adult mental health services as they felt at that point his presenting need was his mental health.

Mental health services advised that Andrew needed to address his alcohol use via Lifeline before he could receive any support for his emotional distress. Mental health services could not support him until his drinking was in control.

Andrew did not want to go to Lifeline and did not want to address his drinking. The result was that Andrew did not receive any additional support.

How do we know that it is not a one off but an underlying issue?

The case group and review team members all reported numerous cases very similar to Andrew's where people have both issues of addiction and emotional distress and the same challenges exist in terms of finding the right support at the right time.

Service providers advised that the way they are commissioned means that services are delivered in a silo way and that commissioning arrangements require clear thresholds and criteria for services. This practice is further embedded in service criteria and policies and procedures.

The strategic needs assessment for Waltham Forest Feb 2017 identified the issue of alcohol and drugs as a cross cutting theme for the four strategic boards and highlighted 'links with adult mental health and additional complexity and cost of dual diagnosis patients'

In Waltham Forest 17% of those entering structured drug support services also have a mental health diagnosis (source: Public Health England).

How common and widespread in this problem?

There is a substantial body of research that identifies that having both an addiction and emotional distress are common. In 2015/16 nationally 22% (source: Public Health England) of those entering structured drug support services also had a mental health diagnosis and there is some indication that this is increasing.

From the recent research from Turning Point '*Dual Dilemma, The impact of living with mental health issues combined with drug and alcohol misuse 2016* 'we learn that**:**

"More than two thirds of people treated for drug or alcohol misuse have experienced mental health issues"

And that

"Research suggests that up to 70% of people in drug services and 86% of alcohol services users experienced mental health problems (PHE, 2014)"

Local data on the numbers of residents in the borough who have both alcohol issues and emotional distress are not yet available but a local population profile is in development and the provider Lifeline confirms that residents with both issues are under-served in the borough.

It is important to note that unfortunately for national and regional data each area uses a different definition for dual diagnosis, and this is best interpreted as a snapshot/best guess for the profile of service clients rather than a prevalence.

What are the implications for the reliability of the system?

A service user having more than one care and support need, creates additional vulnerability. This finding highlights that the current commissioning of services creates significant barriers to professionals providing timely and effective help for people with both alcohol dependency and mental health/emotional distress. The services that are commissioned do not reflect the complex issues that clients are struggling with. The result is that clients who are in effect self-neglecting are not being provided with the support they require to be safeguarded

Societal attitudes towards people that are drinking can be judgmental in that it is seen as a choice to continue drinking and therefore if you do take the help that is offered and stop drinking it is your choice and therefore your problem.

Finding 3

People with alcohol dependency and emotional distress are left with limited options because services are not equipped or commissioned to provide support for both issues together which ignores the interconnected nature of people's dependency and emotional distress.

What would a safe system look like and what impact does this pattern have on safe functioning?

The evidence suggests that commissioners and commissioned services are not provided in line with what is required by service users. Services tend to assume single issue scenarios leaving a poor fit for people like Andrew. Services need to respond and reflect on the complexity and variety of people's needs to ensure that they can receive the right support at the right time and we do not increase the risk and probability of service users falling between services.

Questions for the board to consider

1. Does the board understand the needs of people like Andrew with both alcohol dependency and emotional distress?
2. How is the strategic needs assessment being used to inform the commissioning of services? Does the board have a role to influence how services are being commissioned to be a better fit?
3. What is the cost-benefit analysis of doing something or nothing?

Finding 4

There is no widely used care pathway, or allocation of role or responsibility for the palliative care of self-neglecting adults who are terminally ill, as a consequence of their addictions. For practitioners who are committed to trying to find solutions; raising and talking about the immanency of death is difficult. This leaves frontline workers trying and

often not succeeding to respond appropriately, increasing the risks that people with alcohol dependencies die with little support or dignity. (Management system issue)

Introduction

The delivery of palliative care and helping people to prepare for dying with dignity is a familiar and supported concept for those who are terminally ill with conditions such as cancer. This case has highlighted that people with drug and alcohol dependencies tend not to have as ready access to such services, with service providers continuing to offer treatment and intervention rather than approaching support as a palliative care pathway. This finding explores why.

How did the issue manifest in this case?

Andrew died a predictable and expected death without end of life care planning and support. From the middle of 2015 Andrew's physical health was on a downward spiral of significant decline. He was experiencing a range of symptoms associated with alcoholic induced cirrhosis, including loss of appetite, low mood, vomiting blood and collapsing as well as a 'yellow' tinge to his skin. Staff caring for him and other professionals were increasingly worried about his poor physical and emotional health up until his death in early 2016. The repeated responses of those involved included encouraging Andrew to stop or reduce his drinking, support to attend medical appointments and referrals to other professionals for further assessment.

Even in the last weeks of his life, medical support included ongoing diagnosis and prescribing of drugs for Andrew to try his own community detox (unsupported). The GP did not embark on developing a palliative care pathway with him, instead choosing to provide access to treatment, with a view that if Andrew had stopped drinking even in the last few weeks; this may have extended his life for a few days, weeks or months. This key dilemma to introduce the palliative care pathway when death is inevitable, is frequently avoided. A striking and tragic feature of this case was how everyone avoided saying directly to Andrew at the end that he was dying and instead the energy and focus of service activity remained on further assessment, diagnosis and treatment.

A review of literature shows that end of life care is defined as being patients, 'approaching the end of life', when they are likely to die within the next 12 months. There is little published about the end of life care for those with alcohol dependency, the focus being mainly on the recognition of alcohol dependence and the management of pain relief for those receiving palliative care but with a known history of addiction.

How do we know that it is not a one off but an underlying issue?

Part of the review process involved exploring whether this issue was unique to Andrew's case or represented something more generic. Professionals in the case group and the review team spoke of other cases where there are similar challenges, particularly with homeless and

vulnerable adults with long standing and severe addictions presenting with health conditions and behaviours like Andrew. Activity remains focused on assessment and treatment.

The issue explored by the review team and case group was that of all professionals seemingly being unable to stop assessing and treating and instead to pause and address the implications of Andrew's terminal condition. Through the workshop we heard that it was the expectation of services that it was someone else's job to clarify his position; the hostel staff felt it should be a medical person's job to talk to him about dying; the health staff worried because a date cannot be put upon the inevitable, thus a need to continue to treat and prolong life as long as possible. This is seen in the increased referral activity in the later months of Andrew's life, which gathers greater momentum the more unwell and resistant he becomes. Agencies are trying very hard to make safeguarding or mental health referrals as both offer some clearer policy structure for practitioners.

Terminal illness arising from diseases such as cirrhosis, leading to decompensated liver failure have the same inevitable ending as other terminal conditions, but seems to provide a greater challenge to professionals who are determining care and support. The reasons for this are complex calling on individual's professional, moral and ethical core. Key decisions about when to stop trying to assess and treat are difficult.

How common and widespread in this problem?

Members of the case group related similar challenges with other known vulnerable adults who are self–neglecting whereby their ongoing actions are likely to lead to death. This is of concern with those whose self-neglect arises from alcohol or drug related dependencies. The 2011-2014 Local Alcohol Profile published by Public Health England shows that in Waltham Forest for 15.6% of adults their drinking is harmful or hazardous There are a few existing palliative care pathways recognised or routinely used by the multi-agency partnership in these situations. The importance of end of life care is recognized by the Borough and is a current focused area of improvement.

Nationally health issues associated with alcohol dependency are growing. In 2014, there were 6,831 deaths which were related to the consumption of alcohol, 1% of all deaths. This is an increase of 4% on 2013 and an increase of 13% on 2004. Alcoholic liver disease accounted for nearly two thirds (63%) of alcohol related deaths in the UK. (Health and Social Care Information Centre. England 2016)

The National End of Life Care Intelligence Network published a report in 2013 into deaths from liver disease and the implications for end of life care in England. This report shows there was a 25% increase in liver disease deaths between 2001 (9,231 people) and 2009 (11,575 people)

What are the implications for the reliability of the system?

Whilst only 2% of the population as a whole dies from liver disease, 90% of these people are under 70. More than 1 in 10 deaths of people in their 40s is from liver disease. 60% of deaths from liver disease occurred amongst men and 40% amongst women. The most common diagnosis being alcohol-related liver disease, accounting for well over a third (37%) of all liver disease deaths.

Death is not an easy topic for professionals to discuss with clients or patients, even when it can be foreseen in the course of illness or during the progression of a disease. For liver disease, where the patient population is typically younger and the trajectory of the disease more uncertain than other potentially terminal diseases, care at the end of life poses additional and particular challenges. The End of Life Care Strategy was published by the Department of Health in 2008. This has led to improved end of life care for many. However, many clinicians involved in the treatment of people with liver disease, are immersed in acute care and 'rescuing' patients from complications. Thus considering end of life care issues, care planning and having difficult conversations about death can become obscured. (Getting it Right. NHS February 2013).

Finding 4

There is no widely used care pathway, or allocation of role or responsibility for the palliative care of self-neglecting adults who are terminally ill, as a consequence of their addictions. This leaves frontline workers trying and often not succeeding to respond appropriately, increasing the risks that homeless people with alcohol dependencies die with no support or dignity. (Management system issue)

What would a safe system look like and what impact does this pattern have on safe functioning?

Care pathways and role allocation are part of the design of a system intended to make sure that people get the right help at the right time, in a timely and effective manner. This Finding has highlighted a specific arena where no such pathways or roles exist, leaving it to chance and individual practice, if a person is dying from liver disease or similar illness arising from self- neglectful behaviours. This leaves the task to fall on those untrained, unqualified or unsupported to provide this challenging task.

Liver doctors have developed several predictive models of death and seem to recognise very well the signs leading up to the end phase of life yet surprisingly few have developed programs to help those patients or their families either to appreciate this or to navigate the realities and hurdles of their final months of life. Professionals in the safeguarding system are working to prevent and reduce the likelihood of risk and harm to vulnerable adults. Terminal illness arising from alcohol abuse is often considered as a form of self-neglect; against a back drop of client centered working with competent adults considered able to make choices. Workers cannot stop alcoholics drinking but frequently try to support clients

through to the end of their life. (Getting it Right. NHS February 2013). Clients require a skilled workforce confident to approach and support end of life care.

Questions for the board to consider

1. Does the board know what the provision of end of life care looks like for people with addictions, particularly when they are living in temporary accommodation or rough sleeping?
2. How would an appropriate care pathway be mapped out and where would the most significant burden of responsibility for delivery lie? How could other agencies support this?
3. How could the SAB promote training for substance misuse services staff to recognise the approaching end of life in community patients, including skills in discussing the client's needs and preferences, and introduce them in a timely way to palliative care services.

Appendices

How the *Learning Together* review process was undertaken in this SAR

The *Learning Together* methodology can be used flexibly to provide bespoke proportionate reviews to gather and analyse the data and then develop the appraisal of practice and the findings. How the key components of the methodological heart were undertaken in this SAR:

- Generating the 'View from the Tunnel' – from the data provided by front line staff to reduce 'hindsight bias' and generate a more complete understanding of what happened and why. In this SAR that phase of the process was undertaken by front line staff who were directly involved in the management of the case (including practitioners and commissioners) and line managers at the *Learning Together* Workshops. It was further informed by separate conversations with significant practitioners

- Analysing the data using 'Key Practice Episodes (KPEs)' to 'chunk' up the timeline, to appraise the practice of the professionals and to understand what the contributory factors were. In this SAR that phase of the process was undertaken by front line staff and members of the Review Team at the Learning Together Workshop. The analysis and appraisal work was then developed further by the Lead Reviewers and written up in the Appraisal of Practice, with input from the Review Team.

- The 'Window on the System' – the generic findings which provide a window on the local safeguarding system, is generated through the analysis of learning from the specific case, in order to tease out which pieces of learning have a broader application. This phase of the review was undertaken by the Lead Reviewers and the Review Team. It was begun during the workshop and then developed further in a separate meeting of the Lead Reviewers with the Review Team.

Waltham Forest SAR Process – Key Meetings		
Date	**Key Activity**	**To achieve**
23.02.17	SAR training session for SAB members and local front line staff	Familiarity with the SCIE Learning Together model
07.03.17	Learning Together SAR Workshop for frontline practitioners and managers (Case Group) and Review Team	Gather and analyse case data (Develop view from the tunnel, and start KPEs)
22.03.17	SCIE independent supervision session for Lead Reviewers	To quality assure and support development of appraisal of practice and emerging findings
04.04.17	Meeting of Lead Reviewers and Review Team	Verify developing analysis of practice and input to emerging generic findings
21.04.17	SCIE independent supervision session for Lead Reviewers	To quality assure and support development of appraisal of

		practice and emerging findings
04.05.17	Meeting of Lead Reviewers and Review Team	Review and verify draft appraisal of practice and findings
9.06.17	SAB SAR subgroup meeting review of the SAR report	SAR subgroup to quality assure the SAR report
29.06.17	Lead Reviewers facilitate SAB Findings Workshop	To share findings with SAB and facilitate development of SAB action plan

Members of the Review Team

Member of the Review Team	**Role**	**Agency**
Caroline Budden	Lead Reviewer	Independent
Suzanne Elwick	Lead Reviewer	London Borough of Waltham Forest
Zitha Moyo	CHC/ Adult Safeguarding Lead	NHS Waltham Forest Clinical Commissioning Group
Claire Solley	Interim Head of Safeguarding Adults and DoLS	London Borough of Waltham Forest
Jeremy Nicholas	Assistant Director of Services	SHP
Jane Callaghan	Head of Adult Safeguarding	Barts Health Trust
Ben Voss	Detective Sergeant	Metropolitan Police
Philip Greenstone	Mental Health Social Work Lead	NELFT

Summary chronology of key events

Information taken from integrated chronology

DATE	EVENT
2013/14	Contextual information. Significant contact with adult social care. Presenting concerns were homelessness, unresolved bereavement, non-engagement with professionals, mental health issues. Assessments, 2x professional's meetings, but not attended Referred to SHP. Housed at Wardley Lodge
Jan 2015	Andrew living at Wardley lodge (SHP). Informs staff that his mother has died
Jan/Feb 2015	Ongoing housing and arears issues Referred to Turning Point for substance misuse
25.03.2015	Andrew collects medical history from GP
26.03.2015	GP att. Andrew informs GP that he passed out the day before. Bloods requested
10.04.2015	Appt for blood tests. DNA
14.04.2015	Death of resident at Wardley Lodge. Close friend of Andrew's
4.05.2015	Heavy drinking. Vomiting blood, pain in side and back, skin yellow. DNA medical appts. Continues to drink
12.05.2015	Hospital attendance, but doesn't stay
15.05.2015	SHP raise 'risk of harm' flag to High
27.05.2015	Attends Turning Point
28.05.2015	Blood tests at Whipps Cross Hospital. But refuses colonoscopy. Wants to manage alcohol use and reduction himself
12.6.2015	Attends Turning Point. Andrew reports seeing another resident having seizures, this makes him want to help others DNA GP appointment Reporting that he wants to work
7.7.2015	Andrew not co-operating with needs and risk assessments. Stating that he wants to live independently
22.07.2015	Andrew presenting as confused and grumpy. Described as appearing competent/ making choices
July 2015	Engaged in community work through the Church. Visiting St Luge's Hospital, via the Vicar
14.08.2015	3 Way meeting at SHP. Concerns re lack of engagement and poor physical health
5.10.2015	Physical appearance deteriorates. Jaundiced, not eating, still drinking, does not want to attend GP
21.10.2015	Fails appts, disengages
1.11.2015	Rent arears Agreed to sign on with Green Man medical centre
9.11.2015	Andrew collapsed in café and injured face. Collapsed again at Wardley lodge. Ambulance called refused to attend A&E
11.11.2015	Andrew still not registered with GP
12.11.2015	Andrew unwell, collapsed on street

14.11.2015	Hospital admission. Vomiting blood, black stools. Required blood transfusions
17.11.2015	Self-discharge from hospital against medical advice. Bought alcohol
18.11.2015	GP surgery closes
18.11.2015	Andrew prompted to collect medication. Not interested
23.11.2015	Discharge summary sent from hospital to old GP surgery Drugs prescribed, to be collected later
After 23.11.2015	Letter from Wardley Lodge to hospital expressing concerns about Andrew as his surgery is closed. Wardley Lodge stating will make a safeguarding alert
24.11.2015	Referral from SHP to WF Access and Assessment team for mental health assessment on grounds of self-neglect, history, context and escalating physical health needs
27.11.2015	GP registration
30.11.2015	Access team, NELFT refer Andrew to Lifeline for excessive alcohol intake, cannabis and self-neglect
20.12.2015-3.01.2016	Andrew has failed to attend 5 key worker sessions
12.01.2016	Andrew not eating. Self detoxicating?
13.01.2016	Andrew refusing to attend GP's
15.01.2015	Conversation between SHP and GP re Andrew's health and escalating concerns. Significant activity initiated by GP surgery
15.01.2015	Admission to hospital
20.01.2016	Andrew seen by GP. Detailed session of history, Andrew's admits may have depression and uses drink. Weaning dose of chlordiazepoxide to support community detox. Encouraged to attend Lifeline and other supports
20.01.2015	GP letter to Lifeline
22.01.2016	GP letter for psychiatric referral to Access team. Explains concerns of alcohol, depression, self-neglect and not eating
26.01.2016	NELFT receive referral letter form GP concerning self-neglect
27.01.2015	Andrew attends GP for follow up. Admits to drinking while on medication, but reports it is much less. Appeared more positive, reporting appetite had returned.
1.2.2016	Mental health worker phones SHP to speak with Andrew
1.2.2016	Update form WF Access assessment and brief intervention team. Andrew hostile, stated he was ok, denied having any significant physical health symptoms. Did not want any help.
9.2.2016	Andrew reporting to SHP that he is feeling unwell but refused to attend A&E. GP contacted, emergency appointment made for next day. 4 hourly monitoring of Andrew agreed with him.
10.2.2016	Second urgent referral from SHP to access team in relation to concerns about Andrew – self-neglect, grave concerns re mental and physical health
10.2.2016	Andrew attends GP with support from SHP
11.2.2016	SHP contact Access team concerned about Andrew's 'low mood'.

	Wardley Lodge due to close Andrew described as having capacity but no insight
15.2.2016	Access team (NELFT) receive referral from SHP and attempt telephone triage. Andrew refused to speak to Access worker?
16.2.2016	NELFT telephone call to Andrew who reports that he is confused by referral, he “has all his marbles”. Dismissed that he has depression, only needs help to find somewhere to live. Was asked if he was offered an appointment at Thorpe Coombe would he attend? Reported to have said No
17.2.2017	NELFT discharge Andrew back to care of GP as reported to ‘have failed to engage’
22.2.2016	SHP report that Andrew is not well, he may need an ambulance in the morning
23.2.2106	Andrew taken to hospital by ambulance (999 call). Had been vomiting blood and feeling unwell for 6 days
23.2.2016	Hospital. Assessed by consultant gastroenterologist re Alcoholic cirrhosis. Diagnosed: varices bleeds, grade 2 hepatic encephalopathy and possible progression of cirrhosis. Emergency theatre intervention Andrew very unwell. Slow haemorrhage persisted, worsening respiratory failure Intubated and ventilated but multi organ failure Hospital contact Andrew’s family
23.2.2106	ITU – Do not resuscitate decision, Mother and sister attend and spend most of night with Andrew
24.2.2016	Andrew’s condition continues to worsen 0758 Andrew dies from variceal bleeding, portal hypertension and decompensated alcoholic liver failure

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