Walsall
Safeguarding Partnership

SAFEGUARDING ADULT REVIEW
‘Thomas’

2022

Table of Contents

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Walsall Safeguarding Adults Partnership

1. INTRODUCTION

1.1 Thomas was a 54-year-old white British man who was alcohol dependent. He lived alone in a flat, where he was found dead in 21st June 2020. From January 2020 until June 2020, Thomas was in contact with a number of agencies including the police, the ambulance service, health services, adult social services and specialist alcohol services in response to self-neglect and alcohol dependence. From 1st June, Thomas received four care visits per day from a care agency. Agencies struggled to engage with Thomas, who frequently changed his mind about taking part in detoxification for alcohol dependence.

2. SAFEGUARDING ADULT REVIEWS

2.1. Section 44 of the Care Act 2014 places a statutory requirement on the Walsall Adult Safeguarding Partnership to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Walsall Adult Safeguarding Partnership the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

Arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –
a) identifying the lessons to be learnt from the adult's case, and
b) applying those lessons to future cases.

2.2. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

2.3. All Walsall Safeguarding Partnership members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.4. This case was referred to the SAR Sub-group of the Walsall Adult Safeguarding Partnership in September 2020 and considered for a Safeguarding Adult Review at the meeting on 1st March 2021.

2.5. The SAR Sub-group recommended that this case met the criteria for a SAR and the Executive Group of the Partnership ratified this on 24th August 2021.

2.6. The Safeguarding Adults Review was led by Patrick Hopkinson who is an Independent Consultant in Adult Safeguarding and who had no previous involvement with this case and no connection to the Walsall Adult Safeguarding Partnership Board, or its partner agencies.

2.7. **The review**

This safeguarding adults review commenced on 5th November 2021.

2.9 Key areas to be addressed by the review were:

- Mental capacity
- Legal literacy (risk management)
- Awareness and use of existing options (practice and pathways)
- Impact of Covid
- Inter-agency communication/joint working/expectations/partnership working
- Role of carers (formal/informal)
- Recognition and response to health needs (did alcohol use dominate people's views on him)

2.10 **Contact with family and friends**

2.11 The SAR author met Thomas's ex-partner, who had known Thomas since they were at school together.

3. BRIEF SUMMARY OF CHRONOLOGY AND CONCERNS

3.1. The chronology for this safeguarding adults review covered the period from 11th January 2020 – 21st June 2020, slightly over 6 months.

3.2. The following services were involved with Thomas during the time covered by the chronology:

- Ambulance Service
- GP
- Housing provider
- Police
- Adult Social Services
- The Acute Hospital Trust
- Domiciliary care agency
- The Mental Health Team
- Substance Misuse Service

3.3. **Thomas**

3.4. Thomas was 54 years old when he died. He was a white British man who was alcohol dependent. Thomas had a number of health problems which may have been related to his alcohol consumption. He was described by the carers who supported him during the last month of his life as quiet and uncommunicative.

3.5. Thomas had worked as a self-employed builder and loved to work with wood. He had become dependent on alcohol and other substances and had been homeless. Whilst living at a hostel for homeless people in 2018, Thomas had, according to his ex-partner, been "clean" for 12 months and had helped in the office at the hostel. When Thomas left the hostel, he tried to find work as a builder but, having not worked for 10 years, this proved very difficult, and Thomas lacked the relevant qualification (a Construction Skills Certification Scheme Green Card).

3.6. Thomas had been married and had four children from this marriage. Thomas's ex-partner believed that Thomas had three other children, a total of seven. Thomas's ex-partner explained that Thomas was estranged from his family but was very close to his mother, who later developed dementia. Thomas's ex-partner used to take Thomas to visit her. Thomas's ex-partner believes that Thomas's mother died recently.

3.7. Thomas liked cars and motorbikes and had competed in motorbike scrambling. Thomas's ex-partner explained that Thomas was quite impulsive and did not like waiting. He wanted to lay wooden flooring in his flat in 2020 and had become very frustrated that he could not get the materials to do this due to Covid-19 restrictions. Thomas's ex-partner believed that this impulsivity and impatience contributed to Thomas's substance abuse and although Thomas wanted to stop drinking, he found living on his own and not working too difficult to cope with.

3.8. **Chronology from January 2020 to June 2020**

3.9. On 11th January 2020 Thomas was taken to The Acute Hospital. He had telephoned 999 and was found to be experiencing alcohol withdrawal seizures. Thomas was admitted to hospital but self-discharged on 13th January 2020. Thomas was considered by Manor Hospital to "have insight to make this decision".

3.10. On 14th January 2020 Thomas did not attend his GP for a medication review but did attend on 21st January and was seen by a GP. His medication was changed from Ranitidine to Omeprazole (to treat excessive stomach acid).

3.11. On 6th May 2020, West Midlands Police were contacted by Thomas's ex-partner who had left him on 4th May since he had resumed drinking. Thomas's ex-partner said that she had not been able to contact Thomas, and she was concerned about his welfare. Thomas's ex-partner said that Thomas had been aggressive towards her when she left him and that she did not feel safe visiting him. Thomas's ex-partner explained that Thomas had seizures from alcohol withdrawal and was known to have hallucinations. Thomas had previously stated that he should be dead but had not spoken about any suicidal intentions, nor was Thomas's ex-partner aware of any previous suicide attempts. Thomas had not been dealing with the Covid-19 lockdown restrictions well, which in her view had contributed to his drinking. Thomas's ex-partner said that Thomas was "antipolice".

3.12. The Police spoke to Thomas, who said that he was okay and, "…that everything was in order". Since there were no concerns or criminal matters reported, the contact was closed.

3.13. On 18th May 2020, Thomas's ex-partner contacted Walsall Social Services by telephone with concerns about his alcohol misuse and deterioration in his health. Thomas was soiling himself and not eating properly. With agreement, Thomas's ex-partner visited Thomas but did not consider that an ambulance was required for him. Walsall Social Services also attempted to contact Thomas by telephone but received no reply. The recommendation recorded by Walsall Social Services for its own actions following this was for an urgent care and support assessment and that the self-neglect pathway should be used.

3.14. On 19th May 2020, Thomas's ex-partner contacted Walsall Social Services again to provide more details of Thomas's recent background. Thomas's ex-partner explained that Thomas had been admitted to The Wharf (a homeless hostel) last year and had previously been admitted to hospital. Thomas might have epilepsy, anxiety and depression but was not currently on any medication. He had been prescribed medication following a previous hospital admission for panic attacks. Thomas had last spoken to his GP in January but not since and he had received no support since leaving The Wharf.

3.15. Walsall Social Services contacted Thomas by telephone, who confirmed the current concerns. Thomas said that he was running out of Thiamine so Walsall Social Services telephoned his GP to requested a prescription but this would take 48hrs. Walsall Social Services asked the GP to engage with Thomas and a telephone consultation was to be booked. Walsall Social Services were asked to email a request for further health details.

3.16. On 19th May 2020, the Walsall Access Team and Thomas's GP shared information about Thomas.

3.17. On 20th May 2020, Thomas was taken to The Acute Hospital by ambulance after being found by his ex-partner to have soiled himself and had been advised by adult social services to telephone NHS 111. Thomas was described as "*Frail/not eating sitting in*

urine". Thomas was reported by the ambulance crew to be showing signs of sepsis. Thomas was admitted to hospital in the early hours of 21st May.

3.18. Thomas was treated in hospital for a Lower Respiratory Tract Infection with antibiotics. Thomas's GP was requested to review the prescription of Omeprazole due to Thomas's low sodium levels.

3.19. On 1st June 2020, Thomas was discharged home supported by a domiciliary care provider which was commissioned to provide four care 'doubled-up' (2 carers) calls per day for personal care and meal provision. Carers reported that Thomas had been unwell on 3rd June due to alcohol but otherwise no concerns were reported about him. On 4th June 2020, Thomas's support was reduced from 2 to 1 carers since Thomas was mobile.

3.20. On 5th June 2020, Thomas contacted The Substance Misuse Service and asked for support with alcohol problems. A recovery coordinator contacted him by telephone to introduce the Substance Misuse Service and conduct an assessment. Thomas reported that he was busy waiting on another call and an appointment for an assessment was arranged for 9th June 2020.

3.21. On 6th June, carers telephoned for an ambulance since Thomas was unwell. Thomas was noted by the ambulance crew to have not been eating or drinking since 1st June 2020 and considered Thomas, to be coughing up blood and to be a fire and safeguarding risk. Thomas initially agreed to go to hospital then declined but consented for the ambulance crew to make safeguarding referral. Thomas was advised to contact his GP for follow up. The ambulance crew discussed self-neglect with Thomas and deemed him to have mental capacity to refuse treatment.

3.22. On 7th June, Thomas reported that an attempt had been made to steal his motorbike, but the police could find no evidence of this. Thomas's support was returned to two staff four times a day since he had difficulty standing.

3.23. On 9th June, a Substance Misuse Service recovery coordinator attempted to conduct the telephone assessment which had been agreed on 5th June. Thomas was intoxicated and distressed. He said he had a lighter in his hand and was going to set fire to his flat. The recovery coordinator tried to talk Thomas out of this, ended the assessment and contacted the police to carry out a welfare check. Thomas said that he was only joking. The police attended but initially received no reply from Thomas who was being evasive but then confirmed over the telephone that he was safe and did not want to talk to police officers. No further action was taken. The recovery coordinator followed up the outcome of the contact with the police the next day.

3.24. On 11th June, the Substance Misuse Service recovery coordinator telephoned Thomas to check on his wellbeing and to conduct the planned assessment. Thomas said that he had thought of suicide the previous evening and that he was hearing voices telling him to kill himself. Thomas kept ending the telephone call and then calling back which disrupted the flow of conversation. The recovery coordinator did not complete the assessment due to Thomas's immediate mental health needs and contacted Thomas's GP to report concerns about Thomas's mental wellbeing.

3.25. On 11th Walsall Adult Social Services referred Thomas to the ICS nursing team for a continence assessment.

3.26. In response to a referral from Walsall Adult Social Services, the West Midlands Fire Service attempted to contact Thomas due to concerns about fire risk. On 12th June, fire retardant bedding, a throw and a rug was left with Thomas and fire safety advice was given. A further visit was arranged for 29th June 2020. On the same day an ambulance attended Thomas, who refused assessment and conveyance to hospital. Thomas was considered to have the mental capacity to make these decisions.

3.27. On 12th June the Substance Misuse Service Recovery Worker contacted Thomas's GP to follow up on the events of 11th June. Thomas's GP spoke to Thomas by telephone and urgently referred him to the Walsall Mental Health Team, setting out his history and threats to set fire to his flat and of self-harm. The Walsall Mental Health Team contacted The Substance Misuse Service and advised that they had assessed Thomas and they believed him to have an alcohol problem but not a mental health need. Consequently, further support would not be offered at this time.

3.28. The Substance Misuse Service Recovery Coordinator contacted Thomas's social worker to discuss the case by telephone. The social worker advised that Thomas was disorientated, confused and hallucinating, and that he had soiled himself and the flat. The recovery coordinator advised that the safest place would be for Thomas to be in hospital at this time and that an ambulance should be called. The social worker called for an ambulance.

3.29. On 12th June, a member of staff from the Intermediate Care Service Team visited Thomas. Thomas did not feel well and continued to drink heavily and was drinking at the time. Thomas appeared to be confused. The ICS worker was worried about Thomas's safety since he was smoking in bed and drinking heavily. They also reported that he had been soiling himself due to being intoxicated.

3.30. The clinician from EAS spoke with recovery coordinator at The Substance Misuse Service. The primary concerns were about Thomas's alcohol abuse and not his mental health. Their view was that Thomas's alcohol use needed to be addressed first. The Substance Misuse Service recovery coordinator advised that Thomas will be taken to A&E as he was confused and that the GP reported that Thomas has been hallucinating. The ICS worker was uncomfortable about taking Thomas to A&E as he was 'unsteady on his feet'. An ambulance was called. Thomas allowed basic observations and then asked the crew to leave. Thomas was deemed to have the mental capacity to make this decision and was advised to contact the urgent care centre and his GP if he still felt unwell.

3.31. On 13th June, Thomas was taken to The Acute Hospital after trying to cut his wrist. He left by taxi before being treated. The police were informed and began to look for him but Thomas was found back at his flat by the domiciliary agency carers.

3.32. Thomas was visited by a social worker but initially refused to return to hospital. The social worker notified the police of this, who suggested that an ambulance should be

called and that they would attend if the ambulance crew needed support. An ambulance and the police attended, but Thomas was judged to have the mental capacity to refuse to go to hospital. The Social worker completed a Mental Capacity Assessment for Thomas's drinking and self-harm and concluded that Thomas had mental capacity.

3.33. A Mental Health Act Assessment was undertaken on 13th June 2020 at Thomas's home, following a referral from Adult Intermediate Care Services. The referral noted that Thomas had attempted to cut his wrist that morning and that an ambulance had attended his home. Thomas refused to attend A&E and continued to have thoughts of self-harm and planned to cut himself or burn his flat down. The assessing team agreed that Thomas did not require hospital admission or detention under the Mental Health Act. Thomas was described as appearing to have mental capacity during the assessment. Thomas was noted to be alcohol dependent and to feel that detoxification would be the best approach to take. Thomas agreed to attend The Acute Hospital the following day to receive help for his alcohol dependency. The assessing clinician advised that they would inform his GP and alert the Trust Psychiatric Liaison Team should he attend A&E. Thomas would continue to be supported by carers until then.

3.34. On 15th June, Thomas was brought to The Acute Hospital by ambulance after self-harming and had superficial lacerations to his wrist. He also complained of rectal bleeding but refused to be examined. Thomas was reported to have one can of beer with him and to not be withdrawing from alcohol. Thomas refused to engage in the assessment and self-discharged without completing a full assessment of his mental health. He was found outside by a Psychiatric Liaison Nurse but chose to go home and to not engage in detoxification.

3.35. Thomas was deemed to have capacity to make decisions about his care and treatment. The Psychiatric Liaison Nurse recorded that his issues were mainly due to alcohol and that Thomas remained at high risk of self-harm in the context of ongoing alcohol abuse and his reluctance to engage in interventions to address this. Thomas support from the domiciliary care provider was considered to mitigate against these risks. The Substance Misuse Service was not working with Thomas at present as each time they have attempted to assess him he has been incoherent due to drink.

3.36. The Substance Misuse Service recovery coordinator arranged to present the case at the following weeks' multi-disciplinary team meeting to explore alternative options for engaging with Thomas.

3.37. On 20th June, a District nurse visited Thomas. Thomas said that the wound on hand had healed and would like a visit on 22nd June for a pressure assessment.

3.38. In the early hours of 21st June, Thomas called for an ambulance, reporting incontinence, bleeding and flu like symptoms. With assistance from the Fire Service to gain access, the ambulance crew found Thomas sat up in bed, showing no signs of pain or distress. Thomas refused further assessment and conveyance to hospital. He was considered to have the mental capacity to make this decision, showed no signs of intoxication and was discharged on scene. Thomas was heavily soiled, carers arrived

at 6.45am and supported to him to change his clothes, wash and change and launder his bedsheets

3.39. When the carers returned for the lunch call, they found Thomas lying face down on the living room floor. The carers called for an ambulance and despite resuscitation attempts, Thomas was recorded to have died at 13.54. The cause of death was 1) Bronchopneumonia and 1b) Severe Chronic Obstructive Pulmonary Disease.

4. THE EVIDENCE BASE FOR THIS SAFEGUARDING ADULTS REVIEW

4.1 The Local Government Association Analysis of Safeguarding Adult Reviews April 2017 – March 2019 section 3.4 "*Type of Reviews*" describes a number of "methodological" requirements and related shortcomings of SARs, which can be summarised as follows:

4.2 SARs should connect their findings and proposals to an evidence base. There is, for example, a considerable amount of practice guidance for how to work with people who self-neglect but few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.

4.3 SARs should be based on research. Over 50 Safeguarding Adults Boards have carried out SARs on the same set of circumstances on more than one occasion but have treated each discreetly. The SARs do not refer to each other, build on each other, or ask why it happened again.

4.4 SARs should be analytical. There is too much description and not enough analysis.

4.5 SARs should not shy away from difficult or sensitive topics. Few SARs engage in the legal and financial context of practice or decision making and should raise the impact of funding cuts, government strategy and reductions in services.

4.6 Consequently, this SAR will consider both the research and practice evidence for working with people who self-neglect in the context of alcohol and substance use.

4.7 **The impact of the coronavirus pandemic.**

4.8 The events in the last six months of Thomas's life took place with the context of the coronavirus pandemic and the reaction to it. The First phase of the pandemic began in 2020. On 16th March 2020, the Government advised against non-essential travel and encouraged working from home in all but exceptional circumstances. On 20th March 2020, entertainment venues were also ordered to close.

4.9 On 23rd March 2020, the government restricted contact between households and the UK population was ordered to "stay at home". The only permissible reasons to leave home were food shopping, exercise once per day, meeting medical needs and travelling for work when absolutely necessary. All shops selling non-essential goods were told to close and gatherings of more than two people in public were banned. These 'lockdown' measures legally came into force on 26th March 2020.

4.10 These restrictions began to be eased in June 2020 and most restrictions were lifted on 23rd June 2020. Thomas died on 21st June 2020.

4.11 **Alcohol-use findings from safeguarding adults reviews**

4.12 The Alcohol Change UK July 2019 report, "*Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017*"; analysed 11 SARs and identified a number of themes common to all the reviews. These were:

- Non-engagement with services
- Self-neglect
- Exploitation of a vulnerable person
- Domestic and child abuse
- Chronic health problems
- Mental health conditions
- Traumatic events triggering alcohol intake
- Lack of family involvement

4.13 The Alcohol Change UK July 2019 report also identified several practitioner perceptions that affected the way that services responded to these themes:

- Behaviours were seen as personal choice
- The extent of alcohol consumption was underestimated
- Lack of service capacity
- Commissioning of services so that they are available and effective
- High thresholds for support and for safeguarding concerns
- Understanding of the Mental Capacity Act and legal literacy

4.14 The extent to which these themes and perceptions were present in Thomas's case will be considered.

4.15 **Self-neglect practice guidance**

4.16 In addition to using a large quantity of alcohol, in the last few years of his life, Thomas was self-neglecting.

4.17 Self-neglect can be defined as, "*the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecter and perhaps even to their community*" (Gibbons et al, 2006, p.16). Of especial relevance to Thomas, whose mother's death preceded his increase in alcohol use, the loss of a loved-one is one of the two most common experiences cited by individuals who self-neglect (the other is being a victim of violence) (Lien et al, 2016). Self-neglect is one of the ten categories of abuse and neglect specified in the adult safeguarding sections of the Care Act statutory guidance.

4.18 There is extensive research into, and guidance on, working with people who self-neglect largely but not exclusively produced by Suzy Braye, Michael Preston-Shoot and David Orr. For the purposes of this SAR, it is sufficient to focus only on a summary of

this guidance. Readers keen to explore the research basis for this guidance will find several of the publications listed in the bibliography to be of value.

4.19 The guidance is that practice with people who self-neglect is more effective where practitioners:

- Seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience
- Work patiently at the pace of the individual, but know when to make the most of moments of motivation to secure changes
- Keep constantly in view the question of the individual's mental capacity to make self-care decisions
- Communicate about risks and options with honesty and openness, particularly where coercive action is a possibility
- Ensure that options for intervention are rooted in a sound understanding of legal powers and duties
- Think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks
- Work proactively to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals.

4.20 In order to do this, the following approaches should be used:

- History taking. Explore and ask questions about how and when self-neglect started
- Be proactive and identify and address repeated patterns of behaviour
- Try different approaches, use advocates (of all kinds, including friends, formal advocates for particular functions including Care Act advocates and community, citizen and peer advocates) and concerned others, raise concerns, discuss risks, maintain contact, avoid case closure
- Ongoing assessment and review of mental capacity.

4.21 **Repeated hospital admissions and contact with services**

4.22 Thomas attended the Manor Hospital four times in the six-month period between January and June 2020. Three of these attendances were in the period from 20th May until 15th June. During this time, Thomas was admitted once (between 20th May and 1st June) and left the hospital twice before being treated. Previous Safeguarding Adults Reviews (for example, that of Andrew, Staffordshire and Stoke, 2022 and Ms H and Ms I, London Borough of Tower Hamlets, 2020) have identified that repeated emergency department hospital admissions (and in Thomas's case frequent attendances) are a potential warning sign of escalation in an adult's vulnerability (Jarvis et al, 2018) and that, for some adults at risk of abuse, hospital admissions may provide the only opportunity for safeguarding interventions to be made (Boland et al, 2014). These interventions should be made on a multi-agency and are more effective if they involve the vulnerable adult and their family as well as professionals.

4.23 Hospital admissions can also provide an opportunity for change: they can allow reflection, reconsideration and the engagement of other agencies and the use of different approaches and interventions (Boutin-Foster et al, 2005; Gersons, 1990).

4.24 **Self-neglect, mental capacity and freedom of choice**

4.25 All the contacts with Thomas took place within a policy context that emphasises choice, independence and personal control and which forms part of an overall neo-liberal Government led approach to adult social care and welfare (Ward et al, 2020).

4.26 Safeguarding Adults Reviews (amongst others Andrew, Staffordshire and Stoke, 2022; Harold, Brent 2022; Adults B and C, South Tyneside; Mr I, West Berkshire and W, Isle of Wight) have increasingly focused on the challenges of practicing in a way which balances the principles of freedom of choice and self-determination with the duties, public expectations and moral imperatives of public services. These take place within a legislative context that includes the Human Rights Act 1998[1], the Care Act 2014[2], the Mental Capacity Act[3] and the Mental Health Act 1983.

4.27 At the intersection of all these factors is the question of the extent to which adults should be left by public services to behave in a way that is objectively detrimental to their health and wellbeing or which threatens their lives. More fundamentally it is question of prioritising freedom of choice or prioritising protection from harm (essentially Articles 8 and 2 of the Human Rights Act 1998). The guidance on working with people who self-neglect helpfully challenges the either/ or nature of this question by asking practitioners to consider:

4.28 Is a person who self neglects really autonomous when:

a) They do not see how things could be different.
b) They do not think they are worth anything different.
c) They did not choose to live this way, but adapted gradually to circumstances
d) Their mental ill-health makes self-motivation difficult.
e) They have impairment of executive brain function.

4.29 Is a person who self neglects really protected when:

a) Imposed solutions do not recognise the way they make sense of their behaviour.
b) Their 'sense of self' is removed along with the risks.
c) They have no control and no ownership.
d) Their safety comes at the cost of making them miserable

4.30 **Decisional and Executive Capacity**

4.31 The extent to which a person who self neglects can put whatever decisions they make into effect should also be considered. In Thomas's case there were concerns about his ability to self-care and to reduce his alcohol intake. Whilst the Mental Capacity Act does not explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice.

4.32 There is also growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function

(which includes working memory, mental flexibility, and self-control and regulation) which in turn impacts on mental capacity. Of relevance is that, compared with control groups, people with frontal lobe damage caused by alcohol use and traumatic experiences:

- Are significantly slower and less accurate at problem solving when it involves planning ahead.
- Persisted with riskier behaviours for longer and were less responsive to negative outcomes.
- Were no different when identifying what the likely outcome of an event would be.

4.33 As a result, people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening.

4.34 Significantly, these cognitive deficits are unlikely to be detected using the verbal reasoning tests frequently used in mental capacity assessments. It does not appear that this was considered when decisions about Thomas's mental capacity were made.

4.35 The proposed revised Code of Practice for the Mental Capacity Act will, subject to consultation, include guidance on assessing mental capacity where there is an impairment in executive functioning and a mismatch between what a person says and what they do. The proposed revisions include that, "A person who makes a decision which others consider to be unwise should not be presumed to lack capacity. However, a series of unwise decisions may indicate an inability to use or weigh information" (section 4.39).

4.36 **The Care Act 2014 and self-neglect**

4.37 Section 1 of the Care Act states that, "*The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's well-being*". A definition of well-being is provided (see appendix 2) but with relevance to Thomas, it is sufficient to note that well-being includes personal dignity (including treatment of the individual with respect); physical and mental health and emotional well-being; and suitability of living accommodation.

4.38 Section 9 of the Care Act (2014) states that where it appears to a local authority that an adult may have needs for care and support, the authority must assess (a) whether the adult does have needs for care and support, and (b) if the adult does, what those needs are. This Care Act duty applies regardless of the authority's view of (a) the level of the adult's needs for care and support, or (b) the level of the adult's financial resources.

4.39 If an adult refuses an assessment, then under Section 11, the local authority is not required to carry one out unless there are concerns about the adult's mental capacity to make the decision to refuse the assessment or that they are experiencing abuse or neglect (s11.29(b)). This includes self-neglect. There are other circumstances in which assessment must be made despite refusal, which are not relevant to this SAR.

4.40 The Care Act also empowers local authorities to meet urgent needs without an assessment (section 19(3)). This is a discretionary power and so does not have to be used but the reasons for the decision to use or not to use this power must be recorded.

4.41 Consequently, the Care Act makes provision to, and allows some flexibility in how to, promote the wellbeing and meet the needs of adults who, like Thomas, self-neglect.

4.42 Adult Social Services commissioned a care package to support Thomas in his home from 1st June until his death on 21st June 2020. Thomas received four care visits per day, seven days per week, starting at 6.45am. These were a 45-minute morning visit to support Thomas with personal care and to prepare food for him and 30-minute visits at lunchtime and teatime for personal care and food preparation and in the evening for personal care. The Domiciliary Care Agency commissioned to do this, provides reablement support to people who have been discharged from hospital and whilst its carers had received training to support people with a range of needs, they did not have any specialist skills in working with people who, like Thomas, use alcohol excessively. One of the challenges identified in the Alcohol Change UK report, "*Commissioning of services so that they are available and effective*", was present.

4.43 **The local strategic context for effective work with people who self-neglect**

4.44 The effective implementation of the practice guidance and the local learning require a supportive strategic context. The guidance on working with people who self-neglect identifies that the policy, procedural and organisational environments that foster effective ways of working are likely to have the following characteristics:

- Agencies share definitions and understandings of self-neglect.
- Interagency coordination and shared risk-management is facilitated by clear referral routes, communication and decision-making systems
- Longer-term supportive, relationship-based involvement is accepted as a pattern of work.
- Training and supervision challenge and support practitioners to engage with the ethical challenges, legal options, skills and emotions involved in self-neglect practice

5. ANALYSIS

5.1 Using this research and practice evidence base it is possible to analyse the way in which the different organisations involved worked with Thomas.

5.2 Thomas, and the response of services to him, shared a number of characteristics with the cases identified in the Alcohol Change UK July 2019 report, "*Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017*". These were as follows:

5.3 **Agencies' struggle to engage with Thomas**

5.4 Between 11th January 2020 and 21st June 2020, there were examples of unsuccessful single and multi-agency attempts to engage Thomas. These ranged from Thomas

refusing to attend hospital, leaving hospital when he did go there and refusing entry to his home and efforts to support him. The majority of the agency contacts with Thomas took place during a relatively brief period of time between 1st and 21st June. These need to be set within the context that at the same time, Thomas was also contacting different organisations for help. For example, Thomas had telephoned 999 for an ambulance on 6th June and NHS 111 on 15th June and had agreed to hospital-based alcohol detoxification on 13th and 14th June.

5.5 Concerns about Thomas's health and welfare may have escalated too rapidly to allow changes in the way that services tried to engage with him, including adaptations to when, where and how Thomas was approached and by whom. Neither was there much time for consideration of the use of other legal powers such as application to the Court of Protection or the use of the High Court's inherent jurisdiction (Alcohol Change UK, 2020).

5.6 Whilst urgent applications to the Court of Protection can be made, they require preparation and are not always successful (for example Aintree University Hospitals NHS Trust v James [2014] AC 591). Using the High Court's inherent jurisdiction is also costly and time consuming. The High Court may make decisions outside of legal precedent and as Southend-on-Sea Borough Council found ([2019] EWHC 399 (Fam)), a judgement in support of the application may not confer any additional powers to take action. In addition, in the test case of London Borough of Tower Hamlets and PB ([2020] EWCOP 34), Justice Hayden warned against setting the bar too high for mental capacity decisions about a person's ability to control their alcohol use and that, "*The presumption of capacity is the paramount principle in the MCA. It can only be displaced by cogent and well-reasoned analysis*".

5.7 Applications to the Court of Protection that are based on a person's past wishes and feelings (for example M vs Mrs N and Ors [2015] EWCOP59) may have more chance of success. Thomas's time of abstinence from alcohol, as explained to the review author by Thomas's ex-partner but apparently unknown to practitioners contemporarily, and Thomas's previous agreements to hospital-based alcohol detoxification may have been relevant matters in forming an argument that when free from the coercive and controlling effect of alcohol dependency, Thomas wished to become alcohol free.

5.8 There is also no protocol or agreement on who should lead on these applications, and there is often an expectation that the local authority should lead even if it has had little previous involvement. Applications to the Court of Protection should in general be made by the organisation that is best placed to act upon the Court's decision. Court of Protection determinations on, for example, medical treatment in hospital should be applied for by health services.

5.9 **Self-neglect**

5.10 There were four references to self-neglect between January and June 2020 and it would appear that this was connected with his use of alcohol.

5.11 The approach to Thomas seems to have been task orientated rather than aimed at *seeking to understand the meaning and significance of the self-neglect, taking account*

of the individual's life experience. For example, there was a lack of history taking to understand Thomas's life and to place his current attitudes and behaviours in any form of context and to use this as a means for engaging with him. Efforts were made by the Substance Misuse Service recovery worker to assess Thomas on 9th and 11th June, but these were frustrated by Thomas's presentation of significant mental health needs. No further understanding was developed of Thomas's past and what might have influenced his current situation and the decisions he made.

5.12 There was a missed opportunity for history taking on 19th May 2020 when Thomas's ex-partner telephoned Walsall adult social services and provided a brief description of Thomas's recent history. Thomas had been in The Wharf (a homeless hostel) last year, he had epilepsy but had not been to his GP. He had previously been admitted to hospital, had anxiety and depression was not currently on any medication but was prescribed medication following a previous hospital admission for panic attacks. He was not receiving any support services. In response, Walsall Social Services contacted Thomas and his GP, asking them to engage with Thomas and to provide details about him.

5.13 Despite these actions, there was a missed opportunity to have found out more about Thomas, his background and about his time at The Wharf and to find out more about what happened afterwards. Referral to the Substance Misuse Service alcohol services could also have been discussed with Thomas.

5.14 The Wharf is a homeless hostel in Walsall, which provides support to enable homeless people to move on to live independently. In the process of this SAR, it was discovered that Thomas had been referred to The Wharf in 2013 or 2014 before being housed through The Wharf's resettlement programme. Thomas was then referred to The Wharf again in 2017 and stayed there until he decided to leave in 2019. The Wharf had no contact with Thomas after this. Further links between The Wharf, the Substance Misuse Service, Adult Social Services and the Mental Health Team could assist in information sharing, follow up after discharge or disengagement and joint working in the future.

5.15 **Exploitation of a vulnerable person**

There was little known about Thomas's social network and circumstances. Thomas reported to the police on 7th June 2020 that an attempt had been made by strangers to steal his motorbike but the police could find no evidence to support this allegation.

5.16 **Domestic and Child abuse**

No information was gathered on Thomas's childhood or any adult experiences of domestic abuse by the organisations that tried to work with Thomas. Thomas's ex-partner later explained to the review author that Thomas was divorced and was now estranged from his family but this appears to have been due to his alcohol dependency.

5.17 **Chronic health problems**

Thomas had chronic health problems which included ultimately fatal gastrointestinal bleeding as a result of alcohol misuse and related health conditions. For example, on 6th June Thomas telephoned 999 to say that he was coughing up blood and on 15th June telephoned NHS 111 to report that he had lost 2/3 pints of blood in his urine and faeces.

5.18 **Mental health conditions**

5.19 Thomas was described to adult social services by his ex-partner as having anxiety and depression on 19th May 2020 but was not receiving treatment for this. This resulted in contact by adult social services with Thomas's GP. On 12th June, Mental Health Services received a referral from Thomas's GP requesting an urgent assessment. Thomas was described as expressing suicidal thoughts with plans and intent and had said that he would set fire to his block of flats or slit his throat. Thomas had mixed anxiety and depression and thought by Mental Health Services to be under The Substance Misuse Service for support with alcohol dependence. The Substance Misuse Service, however, had not been able to assess Thomas because of his mental health needs.

5.20 Thomas's mental health needs and his use of alcohol also led to a "Catch-22" situation. On 9th and 11th June, the Substance Misuse Service Recovery worker attempted to assess Thomas to be able to provide support with alcohol use. On both these occasions, Thomas's mental health needs prevented the assessment from being completed. However, on 12th June, the mental health team contacted the Substance Misuse Service to explain that Thomas's alcohol problems meant that no mental health assessment could be made.

5.21 Despite this recognition that Thomas had mental health needs, there appears to have been an over reliance on alcohol misuse to explain his presentation. Thomas's use of alcohol may have been considered to be a lifestyle choice rather than a response to trauma and an addiction which could have a coercive and controlling influence on the decisions he made. Implicitly, as identified by the Alcohol Change UK 2019 report, Thomas's, *"Behaviours were seen as personal choice"* and resulted this resulted in, "*Mental health service contacts and assessments that did not result in ongoing treatment, including detoxification".*

5.22 The events between 13th June and 15th June illustrate this. On 13th June, Thomas was taken to The Acute Hospital by ambulance after trying to cut his wrist. He left by taxi before being seen. The police were notified but he was found back at his flat by the Domiciliary Care Agency. Thomas was assessed at home under the Mental Health Act 1983/2007 but was not detained. Instead, the plan was for him to attend the hospital again the next day to commence alcohol detoxification. No transport arrangements appear to have been made for this.

5.23 The next day, 14th June, Walsall Adult Social Services spoke to Thomas by telephone who had not yet been to hospital and accepted that he sounded wheezy. Walsall Adult Social Services notified The Acute Hospital that Thomas may attend to be admitted for detoxification. However, Thomas did not return to hospital on 14th June. Domiciliary Care Agency workers telephoned for an ambulance because Thomas was having a

panic attack and because his ex-partner had reported that Thomas had pressure sores. The ambulance service did not consider that there was an emergency reason to attend.

5.24 This represents a missed opportunity for a coordinated approach to admitting Thomas to hospital for alcohol detoxification. Whilst The Acute Hospital had been briefed to expect Thomas, no transport arrangements appear to have been made and the Ambulance Service and the Domiciliary Care Agency do not appear to have been similarly involved in the admission planning for detoxification. A *moment of motivation to secure changes* may have been missed and there was limited sharing of information and coordination between agencies.

5.25 An ambulance was requested in response to Thomas's physical condition but there appears to have been no further action in response to Thomas's wheeziness and panic attack, which suggested he was experiencing breathing difficulties. Thomas had previously been treated with antibiotics during his stay in hospital between 21st May and 1st June for a lower respiratory tract infection. Thomas's Domiciliary Care Agency carer was noted by the ambulance service to have accepted that there was no need for an emergency ambulance and agreed to contact Thomas's GP the next day.

5.26 Instead, Thomas telephoned NHS 111 himself on 15th June because he had injured his wrist again, had fallen out of bed, had been drinking alcohol that morning and claimed that he has lost 2/3 of a pint of blood in his urine and faeces. An ambulance was sent in response to this. Thomass mood was described by the ambulance crew as erratic since he said that he wanted to detoxify but then refused to travel. The ambulance crew persisted, and Thomas boarded the ambulance for a physical assessment. He then agreed to be taken to The Acute Hospital. This was a good example of *Working patiently at the pace of the individual, and knowing when to make the most of moments of motivation to secure changes*

5.27 At the hospital, Thomas was reviewed by the Mental Health Liaison Team in A&E but self-discharged, despite efforts by A&E staff to encourage him before a full assessment of his mental health was completed.

5.28 Thomas was found sitting outside the main entrance of the hospital. A Psychiatric Liaison Nurse spoke to him and Thomas said that he would be fine and would take a taxi home. Thomas was asked if he wanted alcohol detoxification and he replied, 'not again'. Thomas was deemed to have the mental capacity to make decisions about his care and treatment.

5.29 The Psychiatric Liaison Nurse recorded that the issues identified in the Mental Health Act Assessment on 13th June were mainly due to alcohol and that Thomas remained at high risk of self-harm in the context of ongoing alcohol abuse and his reluctance to engage in interventions to address this. Thomas had carers supporting him for personal care needs and meals four times per day and this was considered to mitigate the risks.

5.30 This hospital attendance was an opportunity to have fully assessed whether Thomas was able to make decisions about his care and treatment and to discuss with Thomas

his reasons for refusing alcohol detoxification which he had previously agreed to. Powers for immediate intervention, however, were limited. The Mental Health Act does not allow someone to be sectioned to be treated medically and it would appear that an intervention under the Mental Capacity Act (s6.35 MCA Code of Practice) to save Thomas's life or prevent serious harm followed by immediate application to the Court of Protection, was not indicated or appropriate at the time as he was deemed to have mental capacity to make decisions about his care and treatment.

5.31 Despite the lack of powers for immediate intervention on 15th June the efforts between 13th and 15th June to support Thomas into hospital for alcohol detoxification could have been maintained but instead appear to have been progressed no further. This might have been an opportunity to consider the balance under the Human Rights Act between Article 2 (to protect life) and Article 8 (to protect freedom of choice) and consider whether or not it was now time to prioritise Article 2.

5.32 **Traumatic events triggering alcohol intake**

5.33 There was no exploration of the extent to which Thomas's earlier life had exposed him to traumatic events, with Thomas, his ex-partner or family. There was no exploration of what had led to Thomas's excessive use of alcohol or of his life history. There were opportunities for this 18th, 19th and 27th May when Thomas's ex-partner contacted Walsall Social Services about Thomas. During the telephone conversation on 19th May, Thomas's ex-partner gave some details of Thomas's recent history but there does not appear to have been any further exploration of this with her or with Thomas. Thomas's ex-partner told the SAR report writer, after Thomas had died, that for example, Thomas had been alcohol free and was motivated to remain so when he left the hostel for homeless people that he had been living in. Thomas had found isolation very difficult, and this may have prompted exploration with Thomas of activities or services to reduce his feelings of loneliness.

5.34 There was contact with Thomas's sister-in-law to let her know what Thomas had died.

5.35 **Lack of family involvement**

5.36 Family involvement is a feature in both the Alcohol Change UK report of 2019 and in the guidance on working with people who self-neglect. Thomas's ex-partner contacted the police on 6th May and adult social services on 18th, 19th, 27th May and she also provide support to Thomas in June, assisting the domiciliary carers with Thomas's personal care for example. Whilst these contacts led to actions (to visit Thomas for example) they were essentially transactional (i.e short-term and with a specific goal) rather than relational (i.e. long-term with more general goals) in nature. Even though she was Thomas's ex-partner, she clearly had considerable commitment to Thomas and might have been included by the services working with him as a partner in considering and making interventions. The Domiciliary Care Provider also stated that regular telephone calls were made to another next of kin of Thomas, a niece of a daughter, to update them on how Thomas was. It does not appear that this contact was used to identify any other approaches that could be used to support Thomas. Consequently, in terms of the guidance on working with people who self-neglect,

there little evidence of thinking *flexibly about how family members and community resources can contribute to interventions, building on relationships and networks*.

5.37 Summary of the analysis of the research and practice evidence base

5.38 Considered in the light of both the Alcohol Change UK 2019 report and other safeguarding adults reviews, Thomas's case cannot be considered to be unusual or unique and his circumstances further confirm the pattern already identified by Alcohol Change UK and in other reviews:

- non-engagement with services;
- self-neglect;
- exploitation (although this does not appear to have been a factor for Thomas)
- domestic and child abuse;
- chronic health problems;
- mental health problems;
- traumatic events triggering alcohol intake;
- lack of family involvement;
- high levels of alcohol intake and over-reliance on alcohol use to explain the adult's presentation;
- regular contact with ambulance services and
- unpopularity with the local community or concerned neighbours)

5.39 This pattern might be predictive of poor outcomes unless different approaches are taken. In consequence, services should consider how the presence of this pattern of characteristics might be identified in the future and how this might lead to interventions that result in better outcomes.

6. THE EXTENT TO WHICH PRACTICE WITH Thomas WAS CONSISTENT WITH GUIDANCE ON WORKING WITH PEOPLE WHO SELF-NEGLECT

6.1 In addition to alcohol use, self-neglect and of the characteristics that suggest poor outcomes already discussed, the extent to which the services involved with Thomas applied the guidance on working with people who self-neglect in practice should be considered.

6.2 The approach taken when working with Thomas

6.3 There was considerable evidence of working *patiently at the pace of the individual* with Thomas who was not pressured or persuaded unduly. With the exception of the actions of the ambulance crew on 15th June, this does not seem to have often occurred within the context of knowing when to *make the most of moments of motivation to secure changes.* A training and awareness intervention in this area may be useful (see recommendation 3).

6.4 Exploration of legal options for working with Thomas

6.5 Except for the Mental Health Act assessment on 13th June, there were few attempts to ensure that options for intervention were rooted in a sound understanding of legal

powers and duties. There was little time, but application to the High Court, despite the provisos already outlined in section 5.3 above, might have been productive. The case of London Borough of Croydon -v- CD [2019] EWHC 2943 (Fam), for example, shows that a chronic dependent drinker can be determined to lack the mental capacity to make decisions about their care and, as outlined in section 4.35 above

6.6 Adult safeguarding concerns and responses

6.7 There was little use of adult safeguarding processes. The only reference to safeguarding in the chronology was on 6th June 2020 when an ambulance crew responded to a 999 call from the carers since Thomas had not been eating or drinking since he had been discharged from hospital on 1st June. The ambulance crew considered Thomas to present both a fire and safeguarding risk. Thomas initially asked to go back to hospital but then refused to go. Thomas did give consent for the ambulance crew to make safeguarding referral. There is no record of this referral having been received.

6.8 Since no safeguarding enquiries were made following these concerns it is not possible to predict the extent to which safeguarding enquiries, if they had been made, might have resulted in different outcomes for Thomas. The purpose of an enquiry under Section 42 of the Care Act is to decide, "*whether any action should be taken in the adult's case and, if so, what and by whom*".

6.9 Multi-agency working with Thomas

6.10 Whilst agencies did try to work together, there was little proactive work to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals. There was a multiplicity of organisations involved and a very considerable amount of inter-agency information sharing and communication. There was also evidence of follow up to ensure that messages had been received. Joint working, evidenced by joint visits was regularly practiced. Despite this, few interventions and interactions were coordinated at any level above that of individual case work. There were some attempts to *communicate about risks and options with honesty and openness*, but these took place outside of any intervention that might have capitalised upon them.

6.11 Understanding Thomas's mental capacity to make decisions

6.12 There was extensive evidence of keeping constantly in view t*he question of the individual's mental capacity to make self-care decisions*. Thomas's mental capacity to make decisions about attending hospital but there was little multi-agency awareness of, and response to, repeating patterns and escalation. There was a tendency to consider each assessment of mental capacity as a discrete event and to only focus on Thomas's mental capacity operationally (i.e., Thomas's capacity to consent to a particular intervention) rather than strategically (i.e., in terms of consistency, fluctuation and of deeper questions than just whether or not Thomas would accept treatment at a particular time). This approach has also been described as considering mental capacity as a "video" rather than as a "snapshot". Assessment of Thomas's mental capacity should also have taken place within the context of the effects of Thomas's long-term alcohol use, particularly since there were reports of occasional

aggression (he would throw empty beer cans at his carers), frequent changes of mood and of plans and commitments.

6.13 Substance dependency can be considered to have a coercive and controlling influence on the capacity to make decisions (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/467398/Pt1_Mental_Capacity_Act_in_Practice_Accessible.pdf and London Borough of Croydon -v- CD [2019] EWHC 2943 (Fam)) and can be the cause of the impairment in the functioning of mind and brain, which forms one part of the three part test of mental capacity.

6.14 Case leadership and ownership of responsibility for meeting Thomas's needs

6.15 More broadly, there was a lack of leadership in responding to Thomas's needs. The records provided to the report author show some evidence of managerial oversight when Thomas was discharged from hospital and received a package of care, but work with Thomas was left largely to individual practitioners, who were in regular contact with each other. There does not appear to have been an overall direction to this work or prompts and instructions to escalate to the self-neglect panel and to use the self-neglect pathway (see recommendation 4).

6.16 In summary, some of the key components of effective practice with people who self-neglect were either not applied or were applied insufficiently.

6.17 Facilitators of, and barriers, to effective practice.

6.18 Some explanations for the way that services responded to Thomas were found during interviews and discussions with the staff who worked with Thomas:

6.19 Using the self-neglect pathway

6.20 Practitioners reported they were aware of the Walsall self-neglect pathway but that it was sometimes difficult to use. The pathway relies on willingness to engage but this is sometimes hard to obtain and it takes time to build a relationship. Willingness to engage also fluctuates and visits for face-to-face meetings did not take place during the Covid-19 pandemic.

6.21 The self-neglect guidance and pathway is currently being revised and will be re-launched. It includes tiered guidance so that practitioners can consider what can be done at a single agency level, then at a multiagency level and it also explores the legal steps that are available when they are needed (see recommendation 1)

6.22 Information sharing

6.23 District nurses identified that there was a longstanding problem of relevant information not being included in referrals. These were often completed by doctors who had not actually seen the patient and did not fully describe their pressure care needs. No additional information was included in the referral about Thomas's social circumstances and if these had been known then he may have been seen sooner.

6.24 Similarly, West Midlands Police were reassured by Thomas on 6th May that he did not need help but did not have information on his circumstances and did not find out more about him from his ex-partner. If the police had gathered further information, this might have prompted the need to raise a safeguarding concern about him.

6.25 The Substance Misuse Service did not have basic information (for example date of birth) about Thomas or his background.

6.26 **Understanding of Mental Capacity**

6.27 There was not a general understanding of the coercive and controlling impact of addiction upon Thomas's decision making. Thomas's dependence on alcohol could have been considered to have a coercive and controlling influence on his mental capacity when he was sober. This approach is promoted by the Alcohol Change UK December 2020 report, "*Safeguarding Vulnerable Dependent Drinker*s" (see recommendations 3 and 5_.

6.28 **Thomas's self-neglect, mental health needs and physical health needs were intertwined.**

6.29 **Good Practice**

6.30 There was intensive input by practitioners, especially following Thomas's discharge from hospital on 1st June 2020 and evidence that they worked closely together. There was intense work over short period of time.

6.31 Thomas was provided with a support package of four visits per day when he returned home from hospital on 1st June 2020.

6.32 There was recognition that hospital-based alcohol detoxification would be appropriate, and Thomas's consent was obtained for this.

6.33 The ambulance crew on 15th June showed persistence and staged approach in taking Thomas to The Acute Hospital.

7. CONCLUSIONS

7.2 **Despite knowledge of the self-neglect pathway, practitioners found it problematic to use**

7.3 The pathway relies on the willingness of people who self-neglect to engage which can hard to achieve and it takes time to build a relationship. The pathway is now being revised to include tiered guidance so that practitioners can consider what can be done at single agency and multiagency levels and the legal steps that are available (see recommendation 1).

7.4 Practitioners did not appear to be aware of the existence and purpose of the self-neglect panel, which is a forum at which practitioners can present cases that they are finding difficult to manage (see recommendation 4).

7.5 Thomas's mental capacity to refuse treatment was not explored

7.6 Thomas's mental capacity was infrequently assessed and more often appears to have been assumed. There is no clear evidence that the impact of long-term alcohol use on mental capacity and decision making was recognised by the agencies who were working with Thomas.

7.7 There is extensive research on the impact of life trauma and of alcohol use on the frontal lobe of the brain and associated increases in risk taking behaviour and impulsivity (see section 4.30 above). The Alcohol Change UK Report 2020, Safeguarding Dependent Drinkers states, "*Many patients with frontal lobe damage are wrongly considered to have capacity, because in a simple assessment environment they know the correct things to say and do. When they need to act upon that knowledge in the complex setting of the real world they are driven by impulse and, therefore, can no longer weigh up options*"). Thomas's compulsion to drink may have affected his ability to use and weigh information to make decisions about drinking (see recommendations 2 and 3).

7.8 **Services were not responsive to working with Thomas's mental health problems and alcohol use at the same time.**

7.9 Thomas's mental health needs and his use of alcohol led to a "Catch-22" situation in which his mental health problems prevented assessment for support with his alcohol use and Thomas's alcohol use prevented assessment for support with his mental health needs. This applies only to the assessment stage: mental health services that have already assessed mental health needs can work with people who continue to use substances (see recommendation 5)

7.10 **There was a lack of exploration of the reasons why Thomas might be self-neglecting**

7.11 There was no exploration of the extent to which Thomas's earlier life had exposed him to traumatic events, with Thomas or his ex-partner or family. There was no exploration of what had led to Thomas's excessive use of alcohol or of his life history (see recommendations 2 and 3).

7.12 There was a lack of systematic work with Thomas's wider network including family and friends.

7.13 Thomas's ex-partner contacted the police, adult social services and Domiciliary Care Providers but there was no systematic approach to working with her and with any of Thomas's relatives to identify any other approaches that could be used to support Thomas (see recommendation 2 and 3).

7.14 There was a lack of curiosity about Thomas's background and recent history of using service.

7.15 Thomas had lived at a homeless hostel and during his last stay there in 2019 was able to stop drinking. He had worked in construction and appears to have been motivated to work again. Thomas's background and recent history, however, does not appear to have been enquired into further by practitioners when Thomas came into contact with services in 2020. Curiosity about Thomas would have been useful in formulating strengths-based plans to support him. The homeless hostel, for example, may have been able to provide insights into how to motivate and engage Thomas and might have provided information to establish a context within which to understand Thomas's drinking (see recommendation 2 and 3).

7.16 The Substance Misuse Service, Adult Social Services and the Mental Health Team were not aware of, and do not appear to have had any communication links with, the homeless hostel in which Thomas had lived. Consequently, there was a gap in communication and information sharing between agencies since Thomas's time at the homeless hostel and his move from there were not known by other agencies. (see recommendation 6).

7.17 The restrictions in place as a result of Covid-19 made contact easier but resulted in reduced contextual awareness of needs.

7.18 The two attempts by the Substance Misuse Service to assess Thomas's needs were made over the telephone on 9th and 12th June. On both occasions, the assessment was halted due to Thomas's mental health needs and threats or thoughts of suicide and self-harm. Face to face assessments may have offered an opportunity to place these threats in context and to read body language more effectively. Thomas, for example, later told the police on 9th June that he was only joking.

8. RECOMMENDATIONS

8.1 Domain 1: direct practice with individuals

8.2 Recommendation 1: WSAB should ensure that the self-neglect pathway should include deciding on which organisation should take the lead on applications to the Court of Protection based on which organisation will be able to apply the Court's determination.

8.3 Recommendation 2: The WSAB should seek assurance that partner agencies are promoting trauma informed practice, particularly with people who use substances and self-neglect and that this should be reinforced through training sessions, learning events and one-to-one management meetings.

8.4 Recommendation 3: Training should be commissioned for health and social services staff on understanding the relationship between substance dependency, mental capacity and self-neglect and the practice guidance and legislative framework in which practice takes place including the Human Rights Act, the Mental Health Act, the Mental Capacity Act, the Care Act and public health and environmental health legislation.

8.5 **Domains 2 & 3: Agency and interagency practice**

8.6 Recommendation 4: The WSAB should promote the existence and the function of the Multi-Agency Risk Panel (MARP) as a forum to which practitioners can bring cases to that are difficult and may need some extra impetus and coordination to manage them.

8.7 Recommendation 5: The Mental Health Team and Substance Misuse Service should review the options for joint assessment of people who have mental health needs and are substance dependent and identify how joint assessments can be made.

8.8 Recommendation 6: the Substance Misuse Service, Adult Social Services and the Mental Health Team should develop communication links with The Wharf to assist in information sharing, follow up after discharge or disengagement and joint working with people who are substance dependent

APPENDIX 1: Wellbeing

Section 1(2) of the Care Act (2014) states that:

"Well-being", in relation to an individual, means that individual's well-being so far as relating to any of the following:

a) personal dignity (including treatment of the individual with respect);
b) physical and mental health and emotional well-being;
c) protection from abuse and neglect;
d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
e) participation in work, education, training or recreation;
f) social and economic well-being;
g) domestic, family and personal relationships;
h) suitability of living accommodation;
i) the individual's contribution to society.

APPENDIX 2: HUMAN RIGHTS ACT

All public sector bodies, whether or they are directly or indirectly funded by the UK Government have a duty under the Human Rights Act to discharge the State's positive obligations under the European Convention on Human Rights:

- Article 2 – to protect life
- Article 3 – to protect against torture, inhuman or degrading treatment
- Article 5 – to protect against unlawful interferences with liberty, including by private individuals
- Article 8 – to protect physical and moral integrity of the individual (especially, but not exclusively) from the acts of other persons

APPENDIX 3: MENTAL CAPACITY ACT

The Mental Capacity Act requires a three-stage test of capacity to make decisions:

1. Is the person unable to make the decision? i.e. are they unable to do at least one of the following things:
   - Understand information about the decision to be made, or
   - Retain that information in their mind, or
   - Use or weigh that information as part of the decision-making process, or
   - Communicate their decision (by talking, using sign language or any other means)

2. Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors such as alcohol or drug use?

3. Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to? Individuals can lack capacity to make some decisions but have capacity to make others, so it is vital to consider whether the individual lacks capacity to make a specific decision at a specific time.

APPENDIX 4: Literature review

The literature review was conducted in November-December 2020 using the following resources:

1. An internet search using Google to find open access journals and articles
2. The Royal Society of Medicine's on-line journals and related sources
3. The British Psychological Society's on-line journals and related sources
4. The Athens on-line journals and related sources