Walsall
Safeguarding Partnership

SAFEGUARDING ADULT REVIEW
‘MS’

2022

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SAFEGUARDING ADULT REVIEW

Walsall Safeguarding Adults Partnership

1. INTRODUCTION

1.1 MS was a 58-year-old woman who was alcohol dependent. In November 2019 MS was taken to A&E twice in 11 days with history of falls, confusion, hallucinations and presenting as unkempt. In May 2021 MS attended A&E and the hospital raised a safeguarding concern due to bruising, alcohol misuse, reduced mobility and incontinence. On 24th August 2021 an ambulance crew tried to take MS to hospital, but she declined. Two days later an ambulance was called again as MS was very weak and this time she was admitted to hospital. MS died in hospital two days later of multiple organ failure, the underlying cause of which was alcohol liver disease.

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 on 27th October 2021 and considered for a Safeguarding Adult Review at the meeting on 10th November 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 30th November 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 2nd March 2022.

2.9 Key areas to be addressed by the review were:

- Missed opportunities during November 2019 for health interventions
- WHT following safeguarding referrals/discharge process
- ASC - lack of direct contact with the adult prior to case closure therefore no Section 9 assessment completed (June 2021).
- Primary Care not being notified of safeguarding referrals
- Role of WMAS (further assurance to be sought) and the capacity assessment it carried out.
- Rapid Intervention Team referral - did this happen?
- Missed opportunity of not asking Police to do a safe and well visit
- Evidence of MCA assessments that include awareness of the impact of alcohol abuse. Did practitioners' understanding of the act hinder anything and how did practitioners understand alcohol use?
- How effectively did TB services engage MS, what if anything could have been done differently and were there any wider issues in relation to public health identified and addressed?
- Was there direct questioning about domestic abuse and was NICE guidance about direct questioning complied with?
- Role of the GP. Were there missed opportunities?
- Self-neglect panel/pathway and links with alcohol and drugs dependence
- Information sharing
- Silo working
- Examples of Good practice

2.10 **Contact with family and friends**

2.11 Attempts were made to contact MS's partner but no reply was received.

3. BRIEF SUMMARY OF CHRONOLOGY AND CONCERNS

3.1. The chronology for this safeguarding adults review covered the period from 1st May 2021 – 28th August 2021, slightly under 4 months.

3.2. The following services were involved with MS during the time covered by the chronology and during events in November 2019:

- Ambulance Service
- GP
- Police
- Adult Social Care
- The Healthcare Trust (A&E, Respiratory Services and Tuberculosis Services)
- The Mental Health Partnership

3.3. **MS**

3.4. MS was 58 years old when she died. MS was alcohol dependent and had a history of high levels of alcohol consumption dating back to at least 2006. MS also had a history of fainting and falls and her GP investigated if these were caused by MS's physical health. In the last few months of her life MS was diagnosed with tuberculosis.

3.5. At the time of her death MS was living with her partner (CH) in a hostel and was living on state benefits. MS had a son and a daughter who lived with their biological father. MS was sad that her children did not live with her and believed that if she was able to get a house, then her children could move in with her.

3.6. MS was known to have stress, anxiety and depression caused, or made worse, by the death of her relatives. MS reported to services (GP and mental health services) that she had lost both parents, a brother, an uncle and a niece in the last ten years of her life.

3.7. Little else is known about MS's childhood, previous career or past non-medical history.

3.8. Practitioners described MS as having a very forceful personality, and that she "knew what she wanted".

3.9. **Chronology – events of end of October/ November 2019 and from 1st May 2021 – 28th August 2021**

3.10. On the evening of 31st October 2019 MS attended Walsall Manor Hospital (WMH) Accident and Emergency (A&E) following an alleged assault. She had sustained a 2cm cut to her cheek which was cleansed and dressed. MS said that her husband had beaten her and had done so on previous occasions. A&E staff called the West Midlands Police (WMP) who saw MS in the A&E department. There is no documented evidence

of support offered to MS following this alleged assault and she was discharged from A&E the same evening.

3.11. On 4th November 2019 the West Midlands Ambulance Service (WMAS) notified MS's GP that MS had fallen approximately seven times that day and could not remember her home address. WMP were in attendance and MS was reported to be very unsteady, confused, unwashed and wearing dirty clothes. The ambulance took MS to WMH for further assessment.

3.12. On 15th November 2019 WMAS attended to MS who had fainted outside of a supermarket and fallen down. MS was feeling dizzy and reported that she had been experiencing auditory hallucinations. MS was taken to WMH where Dudley and Walsall Mental Health Partnership (DWMHP) undertook a mental health assessment. During the assessment MS disclosed that she had suffered bereavements during the last few years, including her uncle who had recently passed away. MS reported that a photograph of her uncle had been talking to her. DWMHP noted that MS was unkempt and smelt of stale urine. DWMHP reported that MS was engaging, her speech spontaneous, her mood was "ok" and she appeared fully orientated to time, place and person. DWMHP concluded that there was no indication of concern or vulnerability at that time and that MS was not a risk to self or others.

3.13. MS was seen by psychiatric liaison on 16th November 2019 following her attendance at WMH. After observation, MS was deemed to have been suffering due to grief but not to be unduly depressed or to have any mental illness of note. MS was discharged and refused any form of follow up.

3.14. By December 2019 MS had lost her home and had moved to a hostel in Walsall, having previously lived in Wolverhampton. MS told her GP, who was in Wolverhampton, that she intended to move back to Wolverhampton, but it appears this did not happen.

3.15. On 11th May 2021 MS's GP wrote to MS requesting that she register with a GP in the Walsall area.

3.16. On 27th May 2021 MS attended A&E at WMH following a fall and was transferred to the Acute Medical Unit (AMU). MS had a head injury, bruising and swelling to her left eye and some short-term memory loss. A CT scan was taken of MS's head, spine and thorax.

3.17. On 28th May 2021 nursing staff on the AMU were suspicious about how MS came to be injured and completed a safeguarding referral form which was submitted to the safeguarding lead at the hospital but, by error, not to Adult Social Care (ASC).

3.18. Whilst at the AMU, MS was assessed by an alcohol liaison nurse. A CIWA-AR score was completed. The Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR) is an instrument used by medical professionals to assess and diagnose the severity of alcohol withdrawal. MS had a score of 4 which indicates the absence of or minimal alcohol withdrawal. MS was given pabrinex which provides additional vitamins B and C to correct deficiencies that may have occurred through alcoholism. MS was put on an alcohol withdrawal regime, which was to proceed cautiously due to

MS's head injury. A consultant (at some point during her stay in hospital) stated MS's injury may have due to being punched in the face. MS and her partner denied this.

3.19. On 29th May 2021 MS discharged herself from hospital against medical advice. The hospital noted that MS had the capacity to make decisions, but there is no documentation to evidence any consideration around her capacity to self-discharge. The hospital do not appear to have told ASC about MS's self-discharge, nor do they appear to have reviewed MS's social circumstances despite having raised a safeguarding concern about possible domestic abuse.

3.20. On 7th June 2021 the Safeguarding Lead at WMH checked with ASC if they had received the safeguarding concern to find that they had not.

3.21. In the early hours of 11th June 2021 MS called WMP (who described her as sounding drunk) stating that she had taken in a male (Tad) who had become violent, hitting MS and putting his hand around CH's neck. WMP asked MS some further questions about the incident, but then MS stated everything was "fine" and told WMP to "forget it". WMP stated that they established that MS was safe and well and did not require police attendance, but officers were allocated to visit MS at a later date. It appears that after several failed attempts to speak with MS, WMP contacted CH by telephone on 9th July 2021. CH stated that he had been drinking alcohol when the incident occurred, there had been no further problems with Tad and that he did not wish the police to attend, nor did he wish to make a complaint against Tad.

3.22. Later on 11th June 2021 ASC received the safeguarding concern from WMH which had been raised on 28th May 2021 but not sent, and at 10:19am telephoned WMP to ask that a safe and well check be carried out on MS. ASC explained to WMP that MS was reported to have had a black eye which WMH staff were concerned was caused by a punch.

3.23. ASC told WMP that the safeguarding concern stated that CH appeared to be drunk at the hospital and had said that MS had fallen over. CH had also stated that MS had been falling over for some time but had not received any support. WMP visited MS at home, with both CH and Tad present. The Police Constable spoke to all three separately. MS said that she had felt faint whilst walking down the stairs and had fallen, hitting her head on a wall. She went to hospital, where she was found to have high blood pressure, but self-discharged because she was worried for CH who she stated suffered from blackouts. WMP did not ask MS about her falling on a *regular* basis and there was no consideration that MS was in need of a carer or alcohol rehabilitation services. There appears to be no account taken of the log from earlier that morning which suggests that there had been an alcohol related violent incident or further exploration of the potential domestic abuse of MS by Tad.

3.24. On 14th June 2021 ASC contacted WMP for an update on the safe and well visit and, following this, closed the safeguarding concern on 16th June 2021. It was not progressed to a Section 42 Care Act 2014 enquiry on the basis that MS was able to protect herself.

3.25. On 24th June 2021 MS telephoned 999 and reported that Tad had punched her eight times to the side of her head and had damaged a light fitting. MS sounded drunk during the call and explained that Tad had stayed at her property the night before and had been aggressive since he had arrived. MS said that Tad had been staying with her for the past year and he was no longer being violent as he had gone back to his own property. MS did not wish the police to attend. MS stated she had a small cut to her finger where a wart had become displaced as a result of the assault but declined an ambulance. WMP attended and photographed the damage to the light and the slight injury to MS's finger. MS did not want to pursue the matter and a report was filed without further action.

3.26. On 1st July 2021 Walsall Health Care NHS Trusts' Respiratory Consultant wrote to MS stating that no lesion or primary cancer site had been found in the scan of her lungs that had been taken on 27th May 2021, and therefore MS may have an infection rather than a malignant cancer. A bronchoscopy appointment was booked to exclude active tuberculosis (TB), but due to her memory and alcohol issues MS did not attend for her Covid-19 swabs that were required prior to a bronchoscopy,

3.27. On 16th July 2021 MS telephoned WMP, reporting that Tad had tried to enter her accommodation at the hostel. MS refused to allow him entry and Tad punched her in the face. CH was also inside the property and attempted to intervene, at which point Tad punched CH in the face too. MS told WMP that Tad had left.

3.28. WMP officers attended a few hours later and, on being greeted by CH at the door, heard shouting and banging from an inside room. Upon entering the room they found MS on the floor and Tad present. MS stated that Tad had assaulted her causing her to fall to the floor. Tad was subsequently arrested and further arrested for failing to attend an unrelated court appearance. Once in custody, a telephone statement was obtained from CH but MS refused to provide one. Both were given Victim's Code literature and signposted to victim support services. Tad was charged with assaulting CH, but no further action was taken in relation to MS as she did not support this.

3.29. On 19th July 2021 WMAS were called to the hostel as she had found CH on the floor. CH told the ambulance crew that he had been sitting in the sun, stood up, felt hot and fell to the floor, but that he was fine.

3.30. On 24th August 2021 Tad telephoned 999 for MS and at 7:20pm WMAS attended MS who was not "mobilising'. The crew were told that MS had diarrhoea for the past week and that she was not eating or taking any non-alcoholic drinks. MS's body temperature was high and MS was not able to access the toilet due to clutter so was using a bucket at the bed side for toileting. MS declined to go to A&E against the advice of the crew.

3.31. WMAS tried to get assistance from the Walsall Urgent Community Response team, a Rapid Intervention Team, which no capacity to visit that evening, so a request was made for them to visit the following morning. The Walsall Urgent Community Response team have no record of this referral, although it is possible that the referral was made by telephone but not noted. WMAS raised a safeguarding concern with the ASC emergency duty team (as it was outside daytime working hours). The concerns were that both MS and her partner were alcohol dependent, that the property was

dirty and cluttered, that MS was not eating and was emaciated, that MS was receiving no support, that she was choosing to self-neglect and that she was being neglected by her partner too. WMAS reported that MS refused to go to hospital and had the mental capacity to do this.

3.32. On 25th August 2021 ASC contacted MS's GP surgery for contact details for MS (WMAS had not provided any with their safeguarding referral). The surgery advised ASC to email the surgery with this request, which ASC did stating the contact details were needed for an urgent safeguarding concern. ASC received the information from the surgery six days later. On 25th August 2021 ASC checked that MS had not been admitted to hospital and left telephone messages with MS's partner for MS to call ASC. ASC also decided to carry out a care and support assessment on the basis of the concerns received about care, support and self-neglect.

3.33. On 25th August 2021 the Respiratory Consultant wrote to a TB consultant asking for a review and requesting that MS be advised that her T-spot test from April was positive. The Respiratory Consultant asked the TB Consultant to consider starting TB treatment for MS because her partner and close friend were both being investigated / treated for TB.

3.34. On 25th August 2021 the Respiratory Consultant wrote to MS saying that following a scan of her lungs on 27th May 2021 lung cancer had been ruled out. However, in view of MS's contact her partner and a close friend who had TB and the changes in her lungs which might suggest TB, a referral had been made to the TB team to consider starting her on anti-TB treatment.

3.35. On 26th August 2021 WMAS received a telephone call to attend the hostel for MS. The crew assessed her National Early Warning Score (NEWS2) as 9. A score of 9 classes the clinical risk as high and requires an urgent or emergency response. MS was confused, tachycardic, had a low temperature and low blood glucose. MS was admitted to WMH. WMAS raised a safeguarding concern with ASC about MS being malnourished, unwell, living in dirty premises with evidence of hoarding and a possible fire risk.

3.36. On 27th August 2021 MS was transferred to the Acute Medical Unit (AMU) at WMH. The hospital notes showed alcohol liver disease recorded as part of MS's past medical history, although the GP records showed no evidence of a definite diagnosis of this. The hospital had a discussion with MS's son who was unaware of how MS had been over the past few months.

3.37. On 27th August 2021 the ASC Locality team contacted the AMC at WMH to advise them of the safeguarding concern that had been raised by WMAS on 26th August 2021. The ASC Locality team asked the AMU to ensure that they made a referral back to ASC for an assessment of MS's care and support needs prior to her being discharged from the hospital.

3.38. On 27th August 2021 the AMU contacted the Respiratory Consultant who told the AMU that MS had possible TB and that she had contact with others who were TB positive. The Respiratory Consultant recommended that TB treatment be commenced. It was noted that if MS decided to discharge herself over the weekend that she could do so

and that Public Health England should be contacted to consider if a court order was warranted to protect public health. MS was advised that she had a probable diagnosis of pulmonary TB, which was a risk to her own life and that of others around her and that she must stay in hospital in her own room due to her infection status.

3.39. Later on 27th August 2021, the medical emergency team were called because MS had reduced responsiveness, low oxygen saturation and low blood sugars. The hospital called MS's son to report that MS's condition had deteriorated and to explain what the current management plan was.

3.40. At 7:50 pm that evening, MS had a cardiac arrest and was transferred to the intensive therapy unit (ITU). She was intubated and sedated.

3.41. The ITU doctor reviewed MS and determined that the cardiac arrest was caused by hypoxia (low levels of oxygen in the blood) and pulmonary TB. MS's sister and son were with MS in the ITU initially and were advised that MS was very unwell, suffering from sepsis and was receiving treatment for multiple failing organs. The hospital notes state that a chest x-ray indicated probable TB and that a mental capacity assessment was to be completed once MS had been transferred from to a ward.

3.42. On 28th August 2021 a discussion was held with the Respiratory Consultant and this concluded that if MS was still not improving after 24-48 hours of full organ support, withdrawal of support could be considered. It was noted that although MS's TB could be treated in isolation, "her other problems including multi-organ failure, self-neglect malnutrition, and non-engagement with health care cannot be ignored". It is not clear whether DNAR/CPR was discussed with MS's family.

3.43. At 10:36pm on 28th August 2021 MS suffered another cardiac arrest. CPR was initiated, but the attempt at resuscitation was unsuccessful and MS died.

3.44. The cause of death was recorded as
1a Multiple organ failure
1b alcoholic liver disease
2 TB, Self-neglect

3.45. The immediate cause of death was multiple organ failure, the underlying cause of which was alcohol liver disease. TB and self-neglect did not cause death but contributed in some way.

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 During the last four months of MS's life the Government reached stages 3 and 4 of its four-step plan to ease Covid-19 restrictions in England. On 17th May 2021 (stage 3) most of the restrictions regarding meeting outdoors were lifted and most businesses were able to reopen and on 19th July (stage 4) all remaining businesses were allowed to reopen.

4.9 To reduce contagion of Covid-19, in March 2020 UK general practices implemented predominantly remote consulting via telephone, video or on-line consultation platforms. On 19th July 2021 the government confirmed that the existing COVID-19 Infection Protection and Control (IPC) guidance continued to apply in healthcare settings and that all general practice surgeries should continue to offer a blended approach of face-to-face and remote appointments, with digital triage where possible.

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

4.11 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

4.12 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

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

4.14 **Self-neglect practice guidance.**

4.15 In addition to using a large quantity of alcohol, MS was self-neglecting.

4.16 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 MS, whose father's death preceded her 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.

4.17 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.

4.18 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.

4.19 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.

4.20 **Repeated hospital admissions and contact with services.**

4.21 MS attended hospital on at least seven occasions in the last two and a half years of her life. On two other occasions an ambulance was called but MS did not attend hospital.

4.22 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 MS'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 level 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 MS 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 MS's case there were concerns about her ability to self-care and to reduce her alcohol intake. Whilst the Mental Capacity Act currently 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 and, subject to consultation, will be included in the proposed revised Code of Practice for the Mental Capacity Act.

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 MS'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 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.

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

4.38 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 MS, 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.

4.39 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.

4.40 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.

4.41 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.

4.42 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 MS, self-neglect.

4.43 No assessment of MS's care and support needs was made and subsequently no care package was provided.

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

4.45 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

4.46 **The Domestic Abuse Act 2021**

4.47 The Domestic Abuse Act 2021 defines abusive behaviour as any of the following:

- physical or sexual abuse
- violent or threatening behaviour
- controlling or coercive behaviour
- economic abuse
- psychological, emotional or other abuse

4.48 For the definition to apply, both parties must be aged 16 or over and 'personally connected', which means that they

- are married to each other
- are civil partners of each other
- have agreed to marry one another (whether or not the agreement has been terminated)
- have entered into a civil partnership agreement (whether or not the agreement has been terminated)
- are or have been in an intimate personal relationship with each other
- have, or there has been a time when they each have had, a parental relationship in relation to the same child
- are relatives

4.49 Controlling behaviour is defined as, "*A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour*".

4.50 Coercive behaviour is defined as, "*An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*

4.51 MS does not appear to have been a relative of Tad's or in the type of relationship that fits the definition of "personally connected". This was not necessarily known at the time, however, and in hindsight it appears that Tad may have had a controlling or coercive relationship with MS and potentially with her partner.

4.52 **Tuberculosis**

4.53 The NHS https://www.nhs.uk/conditions/tuberculosis-tb/treatment/ advises that people diagnosed with pulmonary TB, will be contagious up to about two to three weeks into their course of treatment. The treatment for pulmonary TB is antibiotics for at least six months. The NHS advises that people will not usually need to be isolated during contagious period, but gives guidance on important precautions to take to stop TB spreading to family and friends.

4.54 In accordance with NICE guidance https://www.nice.org.uk/guidance/ng33/chnapter/Recommendations#infection- people with suspected infectious or confirmed pulmonary or laryngeal TB who will remain in a hospital setting (including emergency, outpatients or inpatient care) should be placed in a single room. If this is not possible, the person's waiting times should be kept to a minimum and this may involve prioritising their care above that of other patients.

4.55 Unless there is a clear clinical or public health need, such as homelessness, people with suspected infectious or confirmed pulmonary TB should not be admitted to hospital for diagnostic tests or for care.

4.56 For the purposes of TB control, a broad and inclusive definition of homelessness has been adopted that incorporates overcrowded and substandard accommodation. It includes people:

- who share an enclosed air space with people at high risk of undetected active pulmonary TB (that is, people with a history of rough sleeping, hostel residence or substance misuse)
- without the means to securely store prescribed medication
- without private space in which to self-administer TB treatment
- without secure accommodation in which to rest and recuperate in safety and dignity for the full duration of planned treatment.

4.57 Infection control measures that should be adhered to in non-healthcare settings catering for large numbers of people and populations at high risk of TB (such as detention settings, residential hostels and day centres) are to:

- promote simple respiratory hygiene
- ensure awareness of symptoms of potentially infectious TB to enable prompt healthcare referral.
- work with the local public health team and the local authority to ensure accommodation for people with TB.

- ensure adequate ventilation.

4.58 MS was living in a hostel with her partner who had TB and Tad, who she said was also living with them also had TB.

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 MS.

5.2 **Missed opportunities during November 2019 for health and care interventions**

5.3 On 4th November 2019 MS said that she had fallen approximately seven times and was described as being found wandering around looking unkempt. The police and the ambulance service intervened and MS could not remember her home address, was very unsteady, confused, unwashed and was wearing dirty clothes.

5.4 Following this, MS was admitted to WMH from 4-10th November 2019 with confusion and visual hallucinations. MS had a period of alcohol detoxification as she was deemed to be experiencing alcohol withdrawal but wanted to discharge herself. Medical staff thought she had the capacity to do this, however, nursing staff were of the opposite opinion. With MS's consent her son was contacted, and MS agreed to stay in hospital.

5.5 On 15th November 2019 WMAS attended to MS who had fainted outside a supermarket and had fallen down. MS was feeling dizzy and reported that she had been experiencing auditory hallucinations. MS was taken to WMH A&E where the psychiatric liaison team of DWMHP undertook a mental health assessment. During the assessment MS disclosed that she had suffered bereavements during the last few years, including her uncle who had recently passed away. MS said that a photograph of her uncle had been talking to her.

5.6 DWMHP noted that MS was unkempt and smelt of stale urine. DWMHP reported that MS was engaging, her speech spontaneous, her mood was "ok" and she appeared fully orientated to time, place and person. DWMHP concluded that there was no indication of concern or vulnerability at that time and that MS was not a risk to self or others. No referral for a care and support needs assessment, or for occupational therapy input or other forms of assessment in response to her falls.

5.7 Following some observations, MS was deemed to have been suffering due to grief but was not unduly depressed or experiencing mental illness. MS was discharged and refused any form of follow up.

5.8 This was the second time in 11 days that MS had presented to hospital with a history of falls, confusion, hallucinations and presenting as unkempt. Despite this, no referral was made to ASC for a care and support needs assessment, no safeguarding referral was made despite there being evidence of self-neglect, no referral was made to the Drug and Alcohol service, and despite MS's GP being notified of both hospital attendances, there was no primary care follow through or a discussion with MS about

these episodes when she next attended the surgery a month later on 16th December 2019.

5.9 MS's inpatient detoxification does not appear to have been used as an opportunity for longer term engagement with her and it would appear that she quickly began drinking again.

5.10 **Other missed opportunities**

5.11 There were two other missed opportunities which might have led to further health and social care interventions. The first involved exploration of MS's level of alcohol consumption, and the second the safeguarding concern process.

5.12 Exploration of MS's alcohol consumption

5.13 There is no evidence in records that the GP discussed the possibility of a safeguarding adults referral or an assessment under the Care Act with MS for support due to her increased vulnerability caused by anorexia, stress, anxiety, unexplained blackouts and increased alcohol intake. One of the GP practice's own recommendations from this SAR is to review how it can better recognise, respond to and escalate concerns within the wider safeguarding partnership when adults are repeatedly presenting with deteriorating health and social care needs.

5.14 The amount of alcohol MS reported she consumed varied over time. It appeared particularly high in the period 2009 to 2011. MS had jaundice in 2010 and some of her blood test results were documented as alcohol related. Over time MS's reported alcohol intake reduced. Given that the underlying cause of MS's death was alcohol liver disease it is likely that MS was under reporting her alcohol consumption.

5.15 Whilst the GP regularly discussed MS's alcohol intake with her, there does not appear to be evidence of referring MS to alcohol support services. The GP did not assume that MS's pattern of falls was due to alcohol and sought to rule out other health causes for fainting. However, the falls may have been alcohol induced with MS under reporting her alcohol intake. The difference between MS's self-reports and her presentation could have prompted further enquiry about the extent of her alcohol intake and referral to specialist alcohol support services.

5.16 Safeguarding concerns and the discharge process

5.17 Hospital staff raised a safeguarding concern on 28th May 2021 as they were suspicious that MS had been punched. This was sent to the hospital's own safeguarding lead in the belief that it would be forwarded to ASC. However, the correct procedure was for the hospital staff to send the referral direct to ASC with a *copy* to their own safeguarding lead. Consequently, ASC received the concern on 11th June 2021, a delay of 15 calendar days.

5.18 MS discharged herself on 29th May 2021 against medical advice, but the hospital does not appear to have reviewed MS's social circumstances despite having raised a safeguarding concern about these the previous day. There was a risk that MS was

returning to a place where she was subject to abuse. In addition, the hospital did not appear to have informed ASC of MS's self-discharge. Despite suspicions, there is no evidence that the hospital took any action such as involving WMP following what might have been domestic abuse, notifying domestic abuse services or signposting MS to Women's Aid support. Consequently, insufficient steps were taken to *protect* MS, and to *prevent* further abuse.

5.19 ASC did not visit MS following the safeguarding concern it received on 11th June from the hospital, instead relying on a police safe and well visit. ASC then closed the safeguarding concern with no further follow up. The suspicion of potential domestic abuse contained within this safeguarding concern was communicated to WMP by ASC. When they visited MS they spoke separately to CH and Tad, but it is not clear what they spoke about. WMP do not appear to have linked the suspicion of abuse contained within the safeguarding concern with the pattern of telephone calls made by MS to the WMS alleging abuse (including one earlier the same day). The police asked MS about the alleged fall but not about her frequent falls, which ASC had made them aware of. The police concluded that MS was not at risk based on one fall but did not identify the continuing pattern that might have put MS at risk. This suggests a need to clarify the relationship between safeguarding enquiries under s42 of the Care Act, non-statutory enquiries and police safe and well visits in complex cases involving alcohol use especially where there may be indications of domestic abuse.

5.20 On 27th August 2021 the ASC Locality Team received through ASC's safeguarding processes the third safeguarding concern about MS in less than three months. This was from WMAS detailing matters of self-neglect. The Locality Team expected the AMU at WMH to make a referral back to ASC for a care and support needs assessment prior to MS's discharge. Hospital admissions can provide an opportunity for change: they can allow reflection, reconsideration and the engagement of other agencies and the use of different approaches and interventions. MS's admission to the AMU could have provided an opportunity for ASC to engage with and discuss these with MS directly. Instead, the ASC Locality Team closed the internal "referral" down.

5.21 Acute Medical Units are usually short-stay (between 48 and 72 hours) and had MS lived, she may have been transferred to another ward before discharge. It is unclear what was done to ensure that ASC was notified of her impending discharge back to the hostel so that an assessment of need could be made and appropriate care or safeguards put in place to support MS at home.

5.22 Information sharing, case leadership and ownership of responsibility for meeting MS's needs

5.23 WHT and WMAS kept MS's GP informed when they had contact with MS and when she was admitted to A&E and hospital**.** There were, however, opportunities for information sharing and action that were not taken. For example, WMP do not appear to have advised ASC of possible domestic abuse concerns and there was no referral to the Multi Agency Risk Management Conference (MARAC) process. MS's GP did not make contact with ASC about MS's care and support needs in relation to her falls and mental health. MS's GP was not notified of the three safeguarding referrals. ASC did contact the practice about the second of these three referrals to establish MS's

address, but ASC did not give the practice any details of the concern, other than to say that it was urgent. By the time the second safeguarding referral was received by ASC the GP practice did not consider MS to be their patient as she was not within their catchment area. MS had not registered with a new GP. ASC state that proportionality and relevance are factors when considering whether to inform a person's GP of a safeguarding concern and safeguarding enquiry outcome. They have noted, however, that inconsistencies in their practice have recently been identified through an internal audit**.**

5.24 More broadly this patchy cross-agency information sharing led to a situation where no one was aware of the full picture of MS's complex circumstances and where no one took on case leadership and for instigating joined-up multi-agency inventions.

5.25 **Mental Capacity**

5.26 MS was presumed to have mental capacity and when assessed was found to make capacitous decisions. Not all mental capacity assessments were documented. For example, on 29th May 2021 MS discharged herself from hospital against medical advice. The hospital noted that MS had the capacity to make decisions, but there is no documentation to evidence any consideration of her capacity to self-discharge.

5.27 On 24th August 2021 an ambulance was called by Tad since MS was not mobilising, was emaciated, not eating or drinking any non-alcoholic drink. MS refused to be taken to hospital. The ambulance crew reported that MS had the mental capacity to make this decision, but no detail was given on how this conclusion was reached. Not all mental capacity assessments need to be documented but it may be useful to record assessments for decisions about hospital attendance or self-discharge for people who are substance dependent and self-neglect and may be experiencing coercion and control.

5.28 On 27th August 2021 MS had a cardiac arrest and was transferred to the ITU where she was intubated and sedated. The hospital notes state that a chest x-ray indicated probable TB and that a mental capacity assessment was to be completed once MS had been transferred from to a ward. No mental capacity assessment was completed. (This may have been because MS was not well enough and had been sedated, and she died the following day).

5.29 In the process of this safeguarding adults review, practitioners were asked for their reflections on assessing mental capacity. MS's GP stated that the question of assessing capacity did not arise since MS was presenting as capacitous, for example, MS had a telephone consultation with her GP surgery on 23rd March 2021 regarding itchy legs. MS was asked to send some photos of her legs electronically, which she did within 30 minutes. As far as the GP was concerned MS was engaging with GP services and they felt that there was no reason for them to suspect that she lacked capacity.

5.30 Capacity is also decision and time specific, and it is possible for someone to lack the mental capacity to make certain decisions whilst at the same time to have the capacity to make others.

5.31 The Mental Capacity Act is clear that capacity must be presumed but (as the proposed revised code of practice states), it may be necessary to consider whether a person has capacity to make a specific decision if:

- The decision the person is proposing to take is significantly out of character;
- The decision the person is proposing to take appears to be unwise, especially if they are putting either themselves or others at risk;
- It has already been shown that the person lacks capacity to make other decisions in their life as a result of an impairment or disturbance that affects the way their mind or brain works;
- A deprivation of the person's liberty is necessary for the person's care or treatment.

5.32 The proposed revised code of practice for the Mental Capacity Act provides guidance on the circumstances that might lead to a concern that someone may lack the mental capacity to make a decision and identifies that considering a person's capacity is not the same as assessing their capacity.

5.33 Considering means asking whether there is a proper reason to doubt that the person has the capacity to make the decision in question and the proposed code of practice warns that failure to consider this can be just as harmful for the person as an overly hasty decision that they lack capacity to make the decision.

5.34 Causes of concern that may prompt consideration of mental capacity include repeatedly making decisions that appear unwise and present a significant risk of harm or exploitation or making a particular unwise decision that is obviously irrational or out of character.

5.35 These do not necessarily mean that somebody lacks capacity, since people have a right to make decisions that others may feel are unwise, but they might present a need for further investigation, taking into account the person's past decisions and choices, in, for example, the following situations:

- Has the person developed a medical condition or disorder that is affecting their capacity to make particular decisions?
- Are they easily influenced by undue pressure?
- Might someone be influencing or coercing and controlling them?
- Does the person need more information or support to help them understand the consequences of the decision they are facing?
- If there is a proper reason to doubt that the person has capacity to make the decision, it will be necessary to assess their capacity by applying the test in the Act.

5.36 There is evidence that MS may have been in a coercive and controlling relationship with her "friend" Tad or may have been under undue pressure; and traumatic life experiences and prolonged alcohol use may have resulted in frontal lobe damage; and malnutrition and head injuries may have resulted in brain injury which evidence shows has an impact upon executive functioning. It does not appear that these factors were considered.

5.37 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. 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*". MS's addiction to drink may have affected her ability to use and weigh information to make decisions.

5.38 Response to TB

5.39 TB was a contributory cause of MS's death on 28th August 2021. On 4th February 2021, MS complained to her GP of shortness of breath. She was referred for an X-ray but did not attend. MS was diagnosed with TB in April 2021 through a T-Spot test, which does not differentiate between active TB disease and latent TB infection.

5.40 MS was referred to the respiratory team on 28th May 2021 and a bronchoscopy was recommended to rule out active TB. TB nurses attended MS at the hostel where she was living to persuade her to have the bronchoscopy. Despite this, MS did not attend the bronchoscopy appointment.

5.41 It appears the TB service was to become MS's most recent community contact. During the period 12th April 2021 to 16th August 2021 the TB service had seven telephone conversations with MS and five face-to-face meetings.

5.42 On 25th August 2021 TB treatment was recommended for MS since both her partner and close friend (probably Tad) were being investigated or treated for TB and the changes in MS's lungs indicated that she may have active TB. MS and her GP were advised of this by letter.

5.43 MS was taken to hospital confused, with a rapid heartbeat, a low body temperature and low blood glucose on 26th August 2021. WMAS raised a safeguarding concern with ASC about MS being malnourished, unwell, living in dirty premises with evidence of hoarding and raised a possible fire risk.

5.44 On 27th August 2021, the AMU was notified that MS had possible TB and had been in contact with others who were TB positive. It was recommended that TB treatment commence and that Public Health England be notified to consider a court order to protect public health if MS decided to discharge herself over the weekend.

5.45 MS was advised that she had a probable diagnosis of pulmonary TB, which was a risk to her own life and of others around her and that she must stay in hospital in her own room due to her infection status.

5.46 The NICE guidance highlights TB control risk factors, including hostel residence and substance use which were present in MS's life, and recommends that health services should work with the local public health team and the local authority to ensure accommodation for people with TB. MS, her partner and Tad all tested positive for TB in the hostel where they lived. This suggests a potential development need for appropriate housing for homeless people with TB to reduce the risk of infection spread.

5.47 Alcohol Change UK 2019 report

5.48 MS, and the response of services to her, also 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:

5.49 **Agencies' struggle to engage with MS**

5.50 Agencies struggled to engage with MS. For example, after a fall in January 2017 MS missed two follow-up appointments, which prolonged the time MS was in a walking boot, resulting in stiffness and reduced movement in her ankle.

5.51 After being seen by psychiatric liaison on 16th November 2019 MS refused any form of follow up.

5.52 In December 2019 MS's GP discussed anti-depressant medication with MS and offered her a referral to mental health services, both of which she refused.

5.53 MS did not register with a GP in her new area when she moved to the hostel, despite being advised to do so.

5.54 MS was put on an alcohol withdrawal regime while in hospital in May 2021, but on 29th May 2021, MS discharged herself against medical advice. MS had last engaged in inpatient alcohol detoxification in November 2019 and had wanted to leave, but with her consent her son was contacted, and MS had agreed to stay. No attempt appears to have been made in May 2021 to use a similar approach.

5.55 MS she did not attend for her Covid-19 swabs that were required prior to a bronchoscopy.

5.56 On 24th August 2021 MS refused to go to hospital and the ambulance crew raised a safeguarding concern about self-neglect.

5.57 Despite this evident pattern suggesting that MS refused interventions and struggled to keep to appointments, apart from the TB nurses visiting MS at the hostel, it does

not appear that alternative approaches to engage more effectively with MS were tried.

5.58 **Self-neglect**

5.59 There were concerns that MS was self-neglecting, but these were only recorded in the last days of her life. For example, on 24th August 2021 the ambulance crew attended since MS who was not "mobilising'. The crew were told that MS had diarrhoea for the past week, was not eating food or any non-alcoholic drink. MS body temperature was high. MS was not able to access the toilet due to clutter so was using a bucket at the bed side as a toilet. MS declined to go to A&E against the advice of the crew.

5.60 WMAS raised a safeguarding concern with adult social care emergency duty team (as it was outside daytime working hours). The concerns were that both MS and her partner were alcohol dependent, that the property was dirty and uncluttered, that MS was not eating and was emaciated, that MS was receiving no support, was choosing to self-neglect and that she was being neglected by her partner too. WMAS reported that MS refused to go to hospital but had the mental capacity to make this decision.

5.61 On 25th August 2021 ASC asked MS's GP surgery for contact details for MS (WMAS had not provided any with their safeguarding referral). The surgery advised ASC to email the surgery with this request, which ASC did stating the contact details were needed for an urgent safeguarding concern. ASC received the information from the surgery six days later. By this time MS had died.

5.62 On 25th August 2021 ASC checked that MS had not been admitted to hospital and left telephone messages with MS's partner for MS to call ASC. ASC also decided to carry out a care and support assessment on the basis of the concerns received about care, support and self-neglect. However, an assessment was never carried out because by the time ASC received details of MS's address she had already passed away in hospital.

5.63 The second occasion in the last few days of MS's life when self-neglect was recognised was on 26th August 2021, when WMAS made another safeguarding referral to ASC describing self-neglect, having been called and this time taken MS to WMH.

5.64 It is possible that perceptions of self-neglect influenced professionals' response to MS. For example, on two separate occasions in November 2019 MS was described as "unkempt", yet there seemed to be no recognition that MS was self-neglecting. Sometimes alcohol abuse can be seen as a lifestyle choice, without consideration of what prompted alcohol use in the first place. Sometimes alcohol use becomes part of a cycle, in which mental or physical health needs prompt alcohol and substances abuse, which in turn leads to self-neglect and/or further mental or physical health conditions.

5.65 MS's self-neglect also influenced decision making when she was in hospital at the end of her life. On 28th August 2021 a discussion was held with the Respiratory Consultant which concluded that if MS was still not improving after 24-48 hours of full organ support, withdrawal of support could be considered. It was noted that although MS's

TB could be treated in isolation, "her other problems including multi-organ failure, self-neglect malnutrition, and non-engagement with health care cannot be ignored".

5.66 Because an awareness of self-neglect only appears to have been noted in the final days of MS's life, the approach was 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*. At this stage there was little time for history taking. Earlier awareness that MS was self-neglecting might have enabled the development of a better understanding of the context of her attitudes and behaviours and to use this as a means for engaging with her.

5.67 **Exploitation of a vulnerable person and domestic and child abuse**

5.68 No information was gathered by practitioners on MS's childhood experiences and no children were living with her. There were, however, contemporary concerns that MS was experiencing domestic abuse and evidence emerged during this review that she may also have been exploited and coerced and controlled by a third-party.

5.69 On 16th May 2019, MS telephoned WMP saying a "friend" would not leave her home. On 31st October 2019 MS attended A&E with a cut to her cheek saying her "husband" had beaten her. This was the first and only reference to MS's husband and may have meant her partner. The police were notified.

5.70 On 27th May 2021, MS attended A&E with a head injury, bruising and swelling to her eye and short-term memory loss. MS claimed that these injuries had been sustained in a fall, but hospital staff suspected she had been punched and raised a safeguarding concern. ASC, apart from asking the police for a safe and well visit, took no further action.

5.71 On 11th June 2021, MS telephoned WMP saying that a friend (Tad) had hit her and that he had put his arm around her partner's neck. This was the first mention of Tad who little was known about and who was not MS's partner. MS declined police attendance and later when the police spoke to MS's partner he said he did not want to make a complaint against Tad.

5.72 Later on 11th June 2021, ASC contacted WMP about the safeguarding concern they had received from WMH with the suspicion that MS had been punched. WMP visited and spoke separately to MS, CH and Tad. WMP do not appear to have linked the suspicion of abuse contained within the safeguarding concern with the pattern of telephone calls made by MS to the WMS alleging abuse (including one earlier the same day).

5.73 On 24th June 2021 MS telephoned WMP again, reporting that Tad had punched her eight times. She did not wish to make a complaint. MS said that Tad had been living with her for the past year.

5.74 On 16th July 2021 MS telephoned WMP saying that Tad had punched both her and her partner in the face. Police attended and arrested Tad. MS refused to press charges,

but Tad was charged with assaulting MS's partner and was put before the next available court.

5.75 There does not appear to have been contemporary enquiry about who Tad was and what relationship he had with MS and her partner. By December 2019 MS had lost her home and had moved to a hostel in Walsall, MS described the hostel as a horrible place with drug use and used needles everywhere. On reflection, practitioners believed that MS was taking drugs herself but was unlikely to be a willing dealer. Instead, MS may have been coercively involved in the drugs trade, perhaps as a carrier or cuckooed to provide a base for a drug dealer. MS's refusal to press charges on 11th June, 24th June and 16th July 2021 may have been the result of fear of repercussions but there does not appear to be evidence that this was considered.

4.59 It was not known whether Tad was or had been a partner of MS and in hindsight there is no evidence that he had been. Again in hindsight, Tad's assaults on MS and on her partner do not appear to fit the definition of domestic abuse under the Domestic Abuse Act 2021, but this had not been explored at the time. MS was suffering abuse at her home address perpetrated by someone who was living in the same accommodation.

4.60 MS had mental health needs (anxiety and depression) and physical health problems of blackouts and falling. Domestic abuse is a recognised causal factor in victim mental health problems (Mahase, 2019) and there is also evidence that people with mental health difficulties are more likely to experience domestic abuse than the general population (Rodway, et al, 2014). People with chronic physical health problems are also at increased risk of intimate partner violence compared to partners without chronic physical health problems (Khalifeh et al 2015).

5.76 Significantly, mental and physical health conditions can make victims of abuse more vulnerable, and perpetrators can find it easier to gain control by exploiting their victims' vulnerability to make them even more dependent on them.

5.77 MS's physical and mental health problems may have made her more vulnerable to abuse and the abuse she suffered may have increased the intensity of her mental health problems.

5.78 MS was signposted to Victim Support, but there was no referral to MARAC and there was no coordinated multi-agency approach which recognised the full complexity of and interrelationship between MS's needs and circumstances.

5.79 MS's GP practice (who were unaware that MS was at risk of violence) asked practice reception staff to put a referral through for a multi-disciplinary team (which would include the local authority housing department) to discuss MS's housing position, but it appears the referral was never received by the MDT.

5.80 In summary, more could have been done to support MS with the experience of domestic abuse or abuse. WMP had received a number of telephone calls about potential domestic abuse, and whilst MS generally did not want to press charges, there

was no referral to MARAC, or to seek an Independent Domestic Violence Advocate and there was no referral to Victim Support.

5.81 **Chronic health problems**

5.82 MS had a number of long-term health problems and had fainted and fallen on several occasions. It is likely, as with other people who are alcohol dependent that she sustained head injuries as the result of these falls. These are increasingly linked with brain injuries that can impair executive functioning.

5.83 MS was also described as having lost weight and on 15th July 2019 her weight was the lowest recorded by her GP surgery. The GPs discussed concerns about MS and noted that MS's weight loss needed to be explored further. There is also evidence that malnutrition can lead to brain injuries that can impair executive functioning.

5.84 **Mental health conditions**

5.85 MS was in contact with mental health services, when for example in November 2019, she was brought to hospital after falling. There are other reports of MS suffering from stress, anxiety and depression.

5.86 **Traumatic events triggering alcohol intake**

5.87 In 2011 MS revealed that she had been drinking two bottles of wine a day for at least the last year since her father had passed away and that this had been going on for at least 12 months.

5.88 MS made a number of references to the effects of bereavement. On 9th July 2018, MS's GP noted that MS's brother had recently died, and this had increased MS's anxiety and depression. On 11th July 2018 MS missed a cardiology appointment due to her brother's death.

5.89 MS also spoke about stress, for example, on 15th July 2019 MS returned to the GP surgery requesting a not fit to work note due to stress in her family.

5.90 On 15th November 2019 MS told DWMHP that she had suffered bereavements during the last few years, including of her uncle, whose photograph had been talking to her.

5.91 There was no exploration of the extent to which MS's earlier life had exposed her to traumatic events, with MS or her family. There appears to be no exploration of what had led to MS's excessive use of alcohol, despite opportunities to do this, during, for example, GP appointments.

5.92 MS underwent alcohol detoxification twice, but neither time led to any lasting change. MS'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 she made. Implicitly, as identified by the Alcohol Change UK 2019 report, MS's *"Behaviours were {*may have been*} seen as personal choice"*

5.93 **Lack of family involvement**

5.94 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. MS had children who did not live with her and she wanted to be rehoused so that they could live with her.

5.95 Services were aware of and in contact with MS's son. MS's son had been involved in influencing MS's decision to stay in hospital in November 2019 and on 27th August 2021, following MS's final admission to hospital, was notified of MS's situation, of which he had not been aware for the past two months. The hospital also telephoned MS's son to report that MS's condition had deteriorated and to explain what the current management plan was.

5.96 MS also appears to have had a partner, whom she described as more than a friend. MS's partner, however, lived in the same has hostel as MS and is likely to have used substances too, and was described as such by WMAS. A joint approach to their needs may have enabled them to support each other.

5.97 The "Think Family" approach builds the resilience and capabilities of families to support themselves (Wong et al, 2016). This approach recognises that individuals rarely if ever exist in isolation and that whole-family approaches are often necessary to meet individual and family wide needs.

5.98 The core principles of the "Think Family" approach are that practitioners:

- Consider and respond to the needs of the whole family.
- Working jointly with family members as well as with different agencies to meet needs.
- Share information appropriately according to the level of risk and escalating concerns if they are not otherwise being responded to.

5.99 Such an approach may have led to greater consideration of how all the needs presented by MS's, her partner and her son could have been approached. Think Family could have helped to give attention to the individual needs interacted with, and impacted on, each other and also to how the MS, her partner and son functioned as unit.

5.100 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*.

5.101 **Regular contact with ambulance services and hospital attendances**

5.102 In the last two and a half year's of MS's life, prior to her last admission to hospital on 26th August 2021, MS attended hospital on at least six occasions, and in addition on two occasions the ambulance crew were called but she did not attend hospital. Three hospital attendances were, or were suspected to be, due to violence resulting in significant harm (1st February 2019, 31st October 2019 and 27th May 2021).

5.103 Unusually however, compared with other SARs, MS had few hospital admissions due to alcohol related conditions.

5.104 Unpopularity with the local community or concerned neighbours

5.105 On 31st January 2019, MS claimed that she had been assaulted by neighbours and sustained a wound to her thigh which became infected. This incident was not reported to the police.

5.106 The police were not asked to do a safe and well visit

5.107 On 25th August 2021 when ASC were told MS was 'inactive' at the registered GP Practice and they were struggling to get hold of her, WMP could have been asked to carry out a safe and well check.

5.108 In summary, considered in the light of both the Alcohol Change UK 2019 report and other safeguarding adults reviews, MS's case cannot be considered to be unusual or unique and her circumstances further confirm the pattern already identified by Alcohol Change UK and in other reviews, which are:

- non-engagement with services;
- self-neglect;
- exploitation
- 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

In MS's case at least 10 out of the 11 characteristics were present or highly likely to have been present even if they were not recognised or explored at the time.

5.109 This pattern of characteristics might be predictive of poor outcomes in future cases 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. GOOD PRACTICE

6.1 The TB nurses went out to visit MS at the hostel to seek to persuade her to have a bronchoscopy. It was not standard practice for TB nurses to reach out in this way, but they were proactive because of MS's circumstances.

6.2 MS's GP did not assume that MS's blackouts were due to alcohol intake. The GP made appropriate referrals to specialist cardiology, gastroenterology and neurology

departments and ensured that regular blood tests and investigations were undertaken to attempt to eliminate other physical causes of the blackouts and MS's presenting symptoms.

6.3 GP records show evidence that the GP Practice was heavily involved in MS's care, and consultations had taken place regularly. Practitioners commented that MS's GP had been attentive and more proactive that some practices in other areas.

6.4 Once the GP became aware that MS was no longer living in the GP's catchment area, her GP advised her to find another GP practice giving her time to find another practice and assisting in her search by giving her a list of GP's within the new area, waiting three months before listing MS as an inactive patient.

7. CONCLUSIONS

7.2 There were missed opportunities during November 2019 for health and care interventions

7.3 Agencies did not always recognise, respond to and escalate concerns. MS had presented to hospital twice in 11 days with a history of falls, confusion, hallucinations and presenting as unkempt. Despite this, no referral was made to ASC for a care and support needs assessment, no safeguarding referral was made despite there being evidence of self-neglect, no referral was made to drug and alcohol service, and despite MS's GP being notified of both hospital attendances, there was no primary care follow up or a discussion with MS about these when she attended the surgery a month later. (See recommendation 1)

7.4 MS's inpatient detoxification does not appear to have been used as an opportunity for longer term engagement.

7.5 It is likely that MS under reported her alcohol consumption. The difference between her self-reports could have prompted further exploration of the extent of MS's alcohol intake and the value of additional specialist support. (See recommendation 2)

7.6 The incorrect procedure was use for raising a safeguarding concern

7.7 When WMH staff raised a safeguarding concern on 28th May 2021 as they were suspicious that MS had been punched, they used the incorrect procedure. Consequently, ASC's response to the concern was delayed. (See recommendation 3)

7.8 Insufficient consideration was given to protecting MS from abuse and supporting her as a potential victim of abuse.

7.9 On her return home when she self-discharged from WMH, WMH could have involved WMP about suspected domestic abuse, notified domestic abuse services, advised ASC about MS's self-discharge, and signposted MS to Women's aid support. (See recommendation 4).

7.10 MS was signposted to domestic abuse services, but no MARAC was held and the pattern of telephone calls from MS to the WMP did not result in an escalation of MS's case, nor to a move from signposting to a more proactive engagement with MS about these matters. The regular contact with WMP could have been a sign that something was amiss.

7.11 The enquiry into the safeguarding concern that MS may have been punched was not sufficiently robust and comprehensive.

7.12 ASC did not visit MS on receipt of the safeguarding concern and instead relied on a police safe and well visit. WMP concluded that MS was not at risk based on one fall and did not explore the continuing pattern that might have put MS at risk. It appears that the reason why the safeguarding concern had been raised, which was not primarily about falling but about domestic abuse, had dropped out of collective awareness (See recommendation 5).

7.13 Case leadership

7.14 Patchy cross-agency information sharing led to a situation where no one was aware of the full picture of MS's complex circumstances and needs and where no one took ownership for case leadership and for instigating joined-up multi-agency inventions. (See recommendation 6 and 8).

7.15 Mental capacity assessments and executive functioning

7.16 Full records of mental capacity assessments were not made and, in MS's circumstances and for the type of decisions in question, it may have been useful to do so, for example, decisions about hospital attendance or self-discharge for people who are substance dependent and self-neglect and who may be experiencing coercion and control. (See recommendation 7).

7.17 Mental capacity assessments did not take into consideration that MS may have been in a coercive and controlling relationship with her "friend" Tad or may have been under undue pressure; that traumatic life experiences and prolonged alcohol use may have resulted in frontal lobe damage; and that malnutrition and head injuries may have resulted in brain injury which evidence shows have an impact upon executive functioning. (See recommendation 2).

7.18 TB and homelessness

7.19 NICE guidance highlights TB control risk factors, including hostel residence and substance use which were present in MS's life, and recommends that health services should work with the local public health team and the local authority to ensure accommodation for people with TB. MS, her partner and Tad all tested positive for TB in the hostel where they lived (See recommendation 9).

7.20 Agencies' struggle to engage with MS

7.21 Despite a pattern suggesting that MS refused interventions and struggled to keep to appointments, apart from the TB nurses visiting MS at the hostel, it does not appear that alternative approaches to engage more effectively with MS were tried. There were opportunities to engage with MS, for example, if ASC had visited her following the safeguarding concern raised by the hospital on 28th May 2021.

7.22 Recognition that MS was self-neglecting came too late

7.23 Agency's awareness and perception of self-neglect may have affected practitioner responses to MS and may also have influenced decision making in the last days of her life. Because an awareness of self-neglect only appears to have been noted in the final days of MS's life, the approach was 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*. At this stage there was little time for history taking. Earlier awareness that MS was self-neglecting might have enabled the development of a better understanding of the context of her attitudes and behaviours and to use this as a means for engaging with her. (See recommendation 1)

7.24 Abuse, coercion and control

7.25 There were concerns that MS was experiencing abuse at home and evidence emerged during this review that she may also have been exploited and coerced and controlled by a third-party. MS's physical and mental health problems may have made her more vulnerable to abuse and the abuse she suffered may have increased the intensity of her mental health problems. There was no coordinated multi-agency approach which recognised the full complexity of and interrelationship between MS's needs and circumstances. (See recommendation 6)

7.26 Traumatic events triggering alcohol intake

7.27 There was no exploration of the extent to which MS's earlier life had exposed her to traumatic events, with MS or her family. There appears to be no exploration of what had led to MS's excessive use of alcohol, despite opportunities to do this.

7.28 MS underwent alcohol detoxification twice, but neither time led to any lasting change. MS'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 she made. (See recommendation 2)

7.29 Lack of family involvement

7.30 There was little engagement of MS's family and friends by agencies. MS's partner lived in the same has hostel as MS and is likely to have been alcohol dependent too. A joint approach to their needs may have enabled them to support each other.

7.31 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. A Think Family approach may have been helpful (see recommendation 10).

7.32 Reliance on the hospital ward to make a referral for a care and support needs assessment prior to discharge

7.33 The ASC Locality Team expected the AMU at WMH to make a referral for an assessment of MS's care and support needs prior to her discharge. This was after receiving a third safeguarding concern about MS in less than three months, this time from WMAS detailing matters of self-neglect. Despite these concerns, ASC closed the "referral" down pending notification by the AMU of MS's impending discharge. This was a missed opportunity to have engaged with MS whilst she was in hospital and reconsidered how best to promote her wellbeing, including her safety. AMU's are short-stay and MS may have been transferred to another ward before discharge. In that event it is unclear what measures to notify ASC of MS's impending discharge had been put in place, so that an assessment of need and appropriate care and safeguards could be put in place to support her at home. MS died the following day (see recommendation 11).

8. RECOMMENDATIONS

8.1 **Recommendation 1**: Partner agencies should finalise and re-launch the self-neglect pathway and monitor its implementation.

8.2 **Recommendation 2:** ASC, the Health Care Trust and the Mental Health Partnership should ensure assessments related to alcohol dependency include exploration of the characteristics identified in the Alcohol Change 2019 report so that additional help and support can be offered to assist in addressing some of the triggers for excessive alcohol use and that practitioners know how to refer to, and receive advice from, specialist drug and alcohol services.

8.3 **Recommendation 3**: WHT should ensure that all staff are aware of the correct procedure for raising safeguarding concerns. WHT could do this by issuing a memorandum or message to all staff setting out the correct procedure, requiring that this is read and implemented, and this could be discussed in team and one-to-one meetings. The WHT hospital lead and ward managers could conduct audits to check that all safeguarding concerns copied to the hospital lead have also been sent to the correct adult social services safeguarding address.

8.4 **Recommendation 4**: WHT should review its procedures for discharge including self-discharge so that other agencies (for example, the GP, ASC, the police etc) are alerted where an adult who is at risk of abuse within their home environment leaves hospital and there are concerns about their safety.

8.5 **Recommendation 5**: ASC, in consultation with WMP, should clarify the purpose of police safe and well visits and agree a protocol for their use.

8.6 **Recommendation 6**: Partner agencies should create shared documentation that promotes and prompts multi-agency working and identify a multi-agency forum for

agreeing approaches to individual cases where there are collective concerns about engagement, mental and physical health needs, substance dependency and self-neglect.

8.7 **Recommendation 7**: Partner agencies should review the circumstances in which mental capacity assessments should be recorded, for example, it may be useful to record assessments for decisions about hospital attendance or self-discharge for people who are substance dependent and self-neglect and may be experiencing coercion and control. Partner agencies should provide training on mental capacity assessments with particular reference to those who are substance dependent.

8.8 **Recommendation 8**: The Safeguarding Adults Board is recommended to identify how to further develop a culture of multi-agency collaboration in Walsall when working with people who self-neglect. This will include considering[1]:

The role of the SAB in creating and leading a culture of multi-agency collaboration.

How to create a "shared system of care"[2,3] and parity of esteem between all organisations working with adults at risk in Walsall, in which statutory, contracted, voluntary organisations and charities are included as equal partners with mutual responsibilities and accountabilities.

Asking for assurance that partner organisations, including commissioners, have a focus on multi-agency collaboration throughout all aspects of their work. This will include how services are commissioned and quality assured, policies and procedures and supporting documentation.

Developing and disseminating a shared and commonly understood definition of self-neglect with associated risk indicators.

The tools required to support practitioners to embed multi-agency working and information sharing in their practice. These might include checklists, prompts in forms, inclusion in case discussions, team meetings and supervision, management and appraisal arrangements.

Focusing SAB audits and quality assurance activities on multi agency collaboration.

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[1] LGA (2020) A supportive safeguarding adults board: what can a SAB, alongside leaders from the range of sectors do to support collaborative working at all levels? in '*Understanding what constitutes a safeguarding concern and how to support effective outcomes*. Page 39-40 at https://local.gov.uk/publications/understanding-what-constitutes-safeguarding-concern-and-how-support-effective-outcomes and
LGA (2020) Summary of what needs to be addressed by cross sector leaders to support acting on the messages in this framework in '*Understanding what constitutes a safeguarding concern and how to support effective outcomes*. Page40-41 at https://local.gov.uk/publications/understanding-what-constitutes-safeguarding-concern-and-how-support-effective-outcomes

[2] https://www.dorsetcouncil.gov.uk/documents/35024/281402/Safeguarding+Adults+Review+-+HNH.pdf/1f52c160-6ff4-3031-2663-dfeb8d79319a

[3] https://www.westsussexsab.org.uk/media/fy0jqg02/kings-olr-final-draft.pdf3 A shared system of care is one in which statutory, commissioned and regulatory services work together to improve quality and where problems in service delivery or commissioning are responded to as system wide challenges rather than as matters for a single agency to resolve.

8.9 **Recommendation 9:** Partner agencies should consider appropriate housing for homeless people with TB to reduce the risk of infection spread.

8.10 **Recommendation 10:** Partner agencies should identify how a 'Think Family' approach could be used to involve family members in supporting people who are substance dependent.

8.11 **Recommendation 11:** ASC Locality Teams should not close referrals for an assessment on discharge from hospital in situations where there are safeguarding concerns and have been difficulties with engagement. Instead, referrals should be kept open and contact made with the person in hospital to engage them and to reconsider how best to support them. Hospital admissions can provide moments of motivation for people who, for example, self-neglect.

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 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