Safeguarding Adult Review

"Adult P"

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February 2019

Contents

Appendices

1. Introduction

1.1 This Safeguarding Adult Review (SAR) was commissioned by Southampton Local Safeguarding Adults Board (the LSAB) in November 2016.

1.2 Adult P had been admitted to hospital as an emergency admission on 18th April 2014 with severe abdominal injuries following an assault upon her at her flat. Despite medical intervention and significant surgery she died on 20th April 2014.

1.3 The suspected perpetrator, X was arrested on suspicion of her murder and was recalled to custody following a licence revocation. He is a Category 2[1] offender and was being managed at Level 2 under MAPPA[2] at the time of her death. He was subsequently convicted for her murder.

1.4 As a result of the death the LSAB were required to consider if a SAR should be conducted.

1.5 Under the Care Act 2014, a Safeguarding Adults Board must consider the need to arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. (Care Act 2014, section 44).

1.6 In consideration the LSAB noted;-

1. Adult P was known to services.
2. Adult P had a known history of alcohol dependency which impacted upon her health and wellbeing.
3. Adult P spent a great deal of time homeless
4. There was a substantial history of self neglect
5. There was some concern around financial and sexual exploitation by others toward Adult P.

1.7 This case was therefore selected to be reviewed in that the death met the statutory criteria. An Independent Chair was appointed by the LSAB to facilitate and lead the review. The Independent Chair has no association with the agencies or organisations concerned.

1.8 The Independent Chair would like to thank the review group and frontline professionals from a range of organisations and agencies who have taken the time to assist with the review as well as those staff who supported the review from an administrative perspective.

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[1] Category 2: violent and other sexual offender

[2] Section 325 to 327B of the Criminal Justice Act 2003 (CJA) established multi-agency public protection arrangements (MAPPA) in each of the 42 criminal justice areas of England and Wales. These arrangements are designed to protect the public, including victims of crime, from serious harm by sexual or violent offenders. MAPPA requires criminal justice agencies and other bodies to work together in partnership with these offenders. Level 2 requires active multi-agency management and is for offenders where the ongoing involvement of several agencies is needed to manage the offender. Once at level 2, there will be regular multi-agency public protection meetings about the offender.

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1.9 It is important to note that this death had previously been brought to the attention of the Multi Agency Public Protection arrangements (MAPPA) Serious Case Review (SCR) subcommittee. A mandatory MAPPA SCR was conducted. However this focussed solely upon the perpetrator and did not meet the requirements of a SAR in the terms of capturing learning around working with an adult at risk across agencies.

1.10 The MAPPA SCR was concluded some time before the SAR was commissioned. Access to the full MAPPA SCR report and documents standing behind that report have not been shared with the SAR review group as the MAPPA Chair considered the report too sensitive. This is a decision that lies with the MAPPA Chair.[3] One of the MAPPA coordinators did attend a SAR meeting and this was helpful. That review concludes there was no prior contact with Adult P and the perpetrator though the evidence for this has not been shared. It appears to have been a random act upon a vulnerable adult in her own home by a violent offender out of prison on licence. The summary information provided by the MAPPA process has not been included in this report due to restrictions but readers are able to contact the Hampshire and Isle Of Wight MAPPA coordinator if there are any queries.

1.11 There is no explicit guidance that dictates that the MAPPA process would take precedence over a SAR for the victim. There was a conscious decision made to do a MAPPA SCR and SAR separately.

Equality and Diversity

1.12 The review adheres to the Equality Act 2010. All nine protected characteristics were considered in reference to Adult P. The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010, i.e. age, disability, gender re-assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation.

1.13 There is no information or inference to indicate that any acts or omissions were motivated or aggravated by, ethnicity, faith, sexual orientation, gender, linguistic or other diversity factors. Where Adult P had contact with the police, or in any of the joint working that took place, there is nothing to infer that any of these factors were relevant in the decision-making or how she were treated.

[3] Ministry of Justice National Offender Management Service MAPPA guidance

2. Purpose, Timeframe, Terms of Reference, and Methodology

Purpose

2.1 The overall purpose of a Safeguarding Adult Review is to promote learning and improve practice, not to re-investigate or to apportion blame. The objectives include establishing:

- Lessons that can be learnt from how professionals and their agencies work together
- How effective the safeguarding procedures are
- Learning and good practice issues
- How to improve local inter-agency practice
- Service improvement or development needs for one or more service or agency

Lessons learnt are shared to maximise the opportunity to better safeguard adults with care and support needs, who are or may be at risk of abuse or neglect.

Timeframe

2.2 The time period for the review is from 1st April 2012 until the date of death on 20th April 2014. Appraising the work of agencies further back in time is unlikely to achieve useful systems learning, given the inevitable changes in personnel; local arrangements; national guidance; regulations and legislation. That is not to say that historical information is not considered and this provides an important context and also assists in understanding what was known or knowable by agencies at the time. The Terms of Reference is at Appendix 1.

Methodology

2.3 There is no prescriptive methodology for a SAR though it is now widely accepted that for any multi-agency reviews that a system based approach and methodology is desirable.

2.4 Therefore this review is underpinned by systems methodology to best understand the professional practice within the systems in which professionals work and liaise with partner agencies.

3. SAR Review Group and Practitioners

3.1 The SAR review group consists of senior representatives of the agencies set out below:-

Independent Chair
Hampshire Constabulary
Society of St James
Southampton City Council Housing Services
University Hospital Southampton NHS Foundation Trust
Southampton City Clinical Commissioning Group
Solent NHS Trust including:- Homeless Healthcare Team (HHCT) Nicholstown GP Practice
Southampton City Council Street Homeless Prevention Team
Southampton City Council Independent Domestic Violence Advisor (IDVA) Service (not part of the process)
Southampton City Council Adult Social Care

4. Parallel Processes and Timescale

4.1 Where practically possible a SAR should completed within 6 months of the decision made to proceed with the Review. In this case, this has not been possible for a number of legitimate reasons.

4.2 The SAR review group met on 6 occasions for the SAR. The review group have also considered drafts of this report via email. There have also been visits to single agencies to look at various documentation of the evidence base of several key aspects.

4.3 As the SAR has progressed, learning has become apparent and the agencies have captured this and have worked to make changes and improvements where necessary prior to the review's conclusion.

5. Family involvement

5.1 Information from family members and significant others is an important source of information to understand the wider picture in a review and capture perspectives that professionals and agencies cannot provide.

5.2 This was approached using the principles of family involvement as contained in research[4] for involving families to ensure a sensitive, structured and well prepared

[4] Morris,K.,Brandon,M and Tudor,P. (2012) A Study of Family Involvement in Case Reviews: Messages for Policy and Practice BASPCAN ISBN 13 978 085358 287 8

approach for initial contact, negotiation, information gathering and feedback throughout.

5.3 However, despite this approach and best endeavours it was not possible to gather information from any other family members or significant others. Adult P was a solitary figure who had lost contact with her sibling and was not able to see her son. She had no family members in her life and apart for one relationship with an individual who died before this review no close friends as such. There was one neighbour who is said to have been supportive. This is recorded contemporaneously in key health records as part of a key discussion between professionals and a carer refers to the neighbour. There is however an acknowledgment that not having direct information from either relative or neighbour limits the review to a degree though that is not to say that the learning is not rich.

6. Case Summary

6.1 Adult P had been living in Southampton for many years. She moved there after her son was taken into care by social services but she maintained contact with him via letter and received annual indirect contact with photographs until he reached 18 in 2013 when this contact ceased.

6.2 For much of that time she was in Southampton Adult P was homeless and living on the streets. However at the time of her death she was living in a basement flat owned by a private landlord and supported by carers from Society of St James. The Street Homeless Prevention Team, community health professionals and social services worked extensively with Adult P over many years around her being homeless in the main. Other risks and vulnerabilities included a tendency for her to self neglect and at times not engage to receive help.

6.3 One of the biggest vulnerabilities Adult P posed was that she was alcohol dependent. This dependency had developed in her earlier years and she experienced physical impacts of this including incontinence, convulsions, falls, gastric problems, poor diet and vitamin and other blood deficiencies. It is unclear what impact her chronic alcoholism had on her cognitive ability. However over a period of time some professionals did have concerns that Adult P may be developing brain damage from her longstanding and excessive alcohol consumption.

6.4 Alcohol-related brain damage (ARBD) is a brain disorder caused by regularly drinking too much alcohol over several years. The term ARBD covers several different conditions including Wernicke-Korsakoff syndrome and alcoholic dementia. Whether Adult P had Wernicke-syndrome (WKS) had been queried on several occasions in the hospital setting in the main. This is a type of brain disorder caused by a lack of vitamin B-1. The most common cause of this is chronic alcoholism and it causes a number of cognitive impairments. It was queried on numerous occasions by health professionals whether Adult P had some level of WKS and her mental capacity had been questioned.

6.5 Adult P did have what is described as a personal relationship with a man who was also an alcoholic but she reported to health professionals this was a difficult relationship. While Adult P had some “friends” they were generally drinkers from the street. Adult P did not have a strong social network around her. Adult P had no

family nearby nor was she in touch with her sibling. Adult P did not work. There were occasions when Adult P caused concerns to professionals around her being sexually and financially exploited.

6.6 In March 2011, Adult P saw her GP saying she had been assaulted and that her ribs were bruised. She said she knew her attacker, but would not report this episode to the police. No bruising was evident on examination.

6.7 Adult P also reported at that time to the GP she had problems with diarrhoea which had been ongoing for quite some time. She reported soiling herself on occasions and was also incontinent of urine. Both symptoms were considered to be attributed to her chronic alcoholism. The GP noted that a previous blood test for blood clotting was abnormal. The plan was for further blood tests to check her liver function and cirrhosis markers but these were not done as Adult P declined to cooperate. At this point her mental capacity was assumed. Adult P's incontinence issues did not resolve and she suffered with double incontinence from this point onwards.

6.8 Another vulnerability was Adult P's mental health and emotional wellbeing. Adult P was troubled by depression for some years for which she took medication intermittently. The depression was managed by her GP. Adult P reported on a number of occasions to her GP she was feeling depressed and was keen to take anti-depressants. She stated they lifted her mood and relieved her of her worries. In November 2011 the GP agreed to give 7 days of medication and then review. Adult P permitted the GP to take her blood pressure and weight. She talked of wishing she were not here but that her son was a positive factor in her life.

6.9 In January 2012, Adult P asked for further anti-depressants. She declined a blood test, but said she was not drinking as much as she used to and that she was living in her flat. The GP records that she looked cachectic.[5] The GP recorded she had mental capacity and did not present as thought disordered.

6.10 Professionals who knew and worked with Adult P state that she could be angry and aggressive in presentation when intoxicated but at other times she was cooperative and friendly. Adult P was very well known in the community, to the police and the homeless services including the day centre where which she would sometimes frequent. Adult P tended to be suspicious of others. Despite the endeavours of the Street Homeless Prevention Team, attendance at the local day centre become problematic because of her aggression underpinned by intoxication. Further previous attempts to house her in shared accommodation were not sustainable.

6.11 A private landlord agreed to take her in and this was paid for direct by benefits. The flat he provided was run down, and at times insecure as Adult P would permit other drinkers in and did not always lock her entrance door. For the salient time and up to her death Adult P lived in a poorly maintained and damp basement flat that had no shower facilities and she resided in one room. This was a private tenancy arrangement by a private landlord who was tolerant of Adult P and her rent was paid for with Adult P's benefits and paid direct to the private landlord. The

[5] Physical wasting with loss of weight and muscle mass due to disease. Patients with advanced cancer, AIDS, severe heart failure and some other major chronic progressive diseases may appear **cachectic**.

state of the flat was extremely poor most of the time and she suffered from incontinence. Adult P is reported by professionals to urinate on a rug within that room. Her mattress would become soaked and soiled due to her incontinence. Professionals in contact with Adult P at the time were aware of the poor living conditions.

6.12 The landlord was not actively involved in engaging with Adult P and appears to have not challenged the poor living conditions she lived in as a result of Adult P's self neglect, incontinence and chaotic circumstances caused largely by her alcohol addiction.

6.13 As well as the Street Homeless Prevention Team, community health professionals and the GP, other agencies were involved with Adult P. She attended the local hospitals many times over the years though was not classed as a regular attender.

6.14 Agencies involved with Adult P all reported concerns around her self neglect and vulnerability.

6.15 The professional response was always framed in the context of professionals' judgement that Adult P had mental capacity to make decisions no matter how unwise. Adult P's self neglect was recorded as persistent in the context of alcohol dependency, depression and obvious physical ill health.

6.16 In August 2013 Adult P sustained a fractured pubis rami following a fall. She was admitted to hospital but wanted to go back to her flat. The Emergency Department (ED) nurse spoke to a health professional in the Homeless Healthcare Team and was assured that Adult P had support from a neighbour and that also the Homeless Healthcare Team would support and carers be provided from an appropriate source. On this, as with other admissions to ED, Adult P was offered alcohol services support but she declined stating she did not want to stop drinking. Following this injury Adult P was particularly vulnerable as she had significant reduced immobility.

6.17 There was also a body of information building during late 2013 and into 2014 that Adult P had persons entering into her flat with possible intent around financial and sexual exploitation. This was known by carers, the Homeless Healthcare Team and also an Independent Domestic Violence Advisor (IDVA) who saw Adult P on one occasion. Adult P's flat was not always secure and carers from Society of St James were becoming increasingly concerned. While there was assurance given to the hospital when considering discharge that an elderly neighbour was helping and supporting Adult P it has not been possible to verify this. The service Society of St James, provided was Home Support Services. Their involvement with Adult P was extensive. Their referral form stated ''Long term alcohol misuse. Known for around 20 years or so by Street Homeless Prevention Team…very limited periods of sobriety, allied to substantial periods of homelessness as a result of her drinking. Recent episode of immobility has reiterated how poor her self care is'.

6.18 A certain level of monitoring was possible as Adult P was cooperative with carers going in 3 to 7 hours a week to support and this was positive as she had a tendency not to engage in receiving help for periods at a time. Carers had been

in place since the injury to Adult P's pelvis reduced her mobility greatly. During this time Adult P had to rely upon other drinkers or carers to get her alcohol for her as anything else she needed. Her diet and food consumption was very poor and the flat in a very poor state. However Adult P was considered to have mental capacity at all times and considered to be choosing that lifestyle and environment in which to live.

6.19 In January 2014 at a meeting at Royal South Hants Hospital involving Adult Social Services, Street Homeless Prevention Team and Homeless Healthcare professionals Adult P was described as ''starting to drink whiskey…..(which) coincides with a greater levels of self neglect'' Adult P was also seen by a domestic violence worker as there were concerns around sexual and financial coercion. That worker went to see Adult P and considered her to have mental capacity and when they arrived two men were in the flat which was unsecured though they both left by request. Adult P declined any help from the domestic violence worker.

6.20 Domestic abuse is any incident or pattern of incidents of controlling coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

6.21 Coercive control is "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 means needed for independence resistance and escape and regulating their everyday behaviour" Professionals had concerns around this becoming a factor in Adult P's life compounded by the additional vulnerability brought about by the impact of her pelvic injury. The details of the men entering Adult P's flat were not known nor whether they had been partners of ex partners. The inference is that they were street drinkers but that would be assumption only. A full profile of who was entering the flat, and when and on what basis cannot be accurately ascertained.

6.22 While there were a number of adult risk notifications (CA12's) by the police and concerns expressed by the Homeless Healthcare Team these did not result in further risk assessment or management of Adult P and she was seen as having mental capacity at all times by all agencies.

6.23 On 18th April 2014, a carer arrived and the flat front door was unlocked and partially open. Adult P was found naked apart from a blanket draped round her back and over her shoulders. She had severe abdominal pain and looked unwell. An ambulance was called and Adult P was admitted to hospital in a very poor condition. She was found to have a foreign body in her abdominal cavity which had been forcibly placed there in an assault upon her. Despite the best efforts of health professionals she died two days later on 20th April 2014.

6.24 The perpetrator was found and arrested and as far as can be gathered there does not seem to have been any previous contact between Adult P and the perpetrator and the assault presents as a random act.

6.25 A more comprehensive summary of the chronology of service involvement with Adult P thereafter is set out below in table form.

7. Timeline

7.1 The timeline below sets out a summary of the integrated chronology. It is not an exhaustive list of agency contact but seeks to highlight key periods and events. The text in italics denote comment rather than contemporaneous factual entries in the records.

Date	Event
12th April 2012	Adult P admitted to hospital following an alcohol related convulsion. She was observed and stabilised. She refused some elements of treatment but agreed to take oral medications for the condition. Adult P was assessed to have mental capacity and was refusing to remain in hospital. She self discharged and declined a referral to alcohol services.
1st May 2012	A multi-professional meeting was held. There was no change in Adult P's health. The Street Homeless Prevention Team agreed to monitor the flat and was facilitating repairs. Adult P was noted to need lots of support by health and social care agencies but it was reported there was poor engagement from Adult P.
9th September 2012	Police visited Adult P to follow up concerns to safeguarding from a member of the public (Adult P's neighbour). The neighbour expressed concerns around her poor living conditions and poor maintenance of the property- i.e. no electricity and also Adult P's self neglect. A CA12 (*notification of risk form not a safeguarding referral)* was completed and shared with Adult Social Care. They were concerns were passed onto the Street Homeless Prevention Team as Adult P was known to the team. A visit was made the next day and the neighbour reported Adult P was unwell. Adult P requested help with cleaning up.
5th October 2012	Concerns around wellbeing continued as Adult P was found collapsed on the street. A CA12 was passed to Adult Services. Adult P had been taken to hospital but after initial assessment self discharged herself against medical advice. She was deemed to have mental capacity. She declined further mental health and alcohol services support.
17th March 2013	A CA12 notification was made to adult social care by the police after Adult P was found in a drunken state. Adult P was escorted home safely by police. The CA12 reported poor living conditions and an extreme state of self neglect. Police advised adult social

	care that Adult P was very vulnerable; struggling to live on her own and required assistance. This information was passed onto to the Street Homeless Prevention team. That team agreed to visit to check Adult P's wellbeing and help to clean up the property.
17th March 2013	Adult P was admitted to the Emergency Department (ED) via an emergency ambulance after collapsing in the street following alcohol. No injuries were noted secondary to a fall. Adult P refused blood tests to being taken or to be examined. Adult P was offered a referral to alcohol service and the Vulnerable Adults team whilst in ED. She declined. Adult P self discharged and was judged to have the mental capacity to do so.
20th August 2013	A social care case discussion was held. It was agreed a locality social worker who knew Adult P due to his substance misuse experience would follow the case up.
21st August 2013	Adult P sustained a fracture of her pubic ramus. Contact was made to the Homeless Healthcare Team (HHCT) from the Emergency Department at University Hospital Southampton. HHCT were informed that Adult P had fractured her pubic ramus but was sufficiently mobile to return home and the hospital would arrange transport. A referral was made to Southampton City Council Rapid Response Service[6] to see Adult P daily for personal care and to assist in the cleaning of bedding and the management of incontinence. Adult P was noted to be vague, but this was reported as her normal self and she was known to HHCT. Adult P was difficult to assess, but her right leg was examined. There was no swelling or pain on abduction, adduction, or on weight bearing. Adult P was only able to take a few steps with assistance. She was unhappy to stay in hospital, but aware that an x-ray would be required. Adult P was very vague about the history of how she became injured and the assumption was of a fall. She was intoxicated. Contact was made by the Consultant Nurse in ED to the HHCT who agreed they would visit Adult P the next day at home and that Adult P had good support from her neighbour. Adult P was discharged home following review by the community discharge team regarding mobility. She was issued with a zimmer frame for use at home.

[6] Rapid Response is now known as the Urgent Response Service – the service to helps people to maintain or regain ability and confidence to live at home. Support may only be for a few days, or perhaps longer up to maximum of 6 weeks

	The nurse arranged transport home via a taxi and letter was sent to the GP to advise of the injury. *There was no referral for incontinence services though this remained a significant problem for Adult P.*
23rd August 2013	Adult P declined support from Rapid Response so they do not feel there was any point in attending to assess. *The Rapid Response team assumed mental capacity and did not assess*. It was left for the social worker to assess in 10 days' time. *It is unclear why this the timescale of 10 days was given.*
3rd September 2013	Adult P was seen by the Social Worker. While the visit was conducted Adult P was sat on an old sofa outside her basement bedsit, with a can of lager. Adult P said she was able to mobilise and although covered with some kind of coverlet, appeared to be naked from the waist down. She stated she did not want any further intervention.

6th September 2013	Adult P was noted to be in pain when mobilising. She was taking short term Co-Codamol with a review in 1 week. She declined a blood test. There was a strong suspicion of Adult P having developed osteoporosis and her dietary intake was very poor. Adult P was engaging with the HHCT and carers to receive help and assistance.
9th October 2013	Adult P was seen at home by HHCT and given further supplies of medication. However Adult P was letting other drinkers into the flat despite advice not to do so. She was noted to be moving around better. She referred to profound feelings of sadness, little motivation to get out; poor sleep and dreaming of a deceased friend/partner. Adult P requested anti-depressants and had taken these in the past. She was prescribed anti-depressants for a trial period of 2 weeks to test compliance. Adult P was cautioned that she would not feel the benefit in this short period but that she needed to remain engaged with medication to feel any effect. The effect of alcohol consumption on mood was also discussed. *No formal mental health assessment was undertaken*.

28th October 2013	Adult P had insufficient funds as she had missed a medical assessment for benefits. The Social Worker was dealing with this but Adult P was not prepared to work with the social worker as she erroneously believed he had been involved in her son's removal into care. Adult P was therefore awaiting another social worker allocation.
December 2013	Adult P was allowing street dwelling alcoholics into her property. Adult P was assumed to have capacity to make these decisions. Concerns were that due to her vulnerability, Adult P was putting herself at risk, including the risk of sexual exploitation. HHCT were aware Adult P was awaiting another social worker allocation. A call also made to the Social Worker for Adult P's son (who is now adopted). Adult P was concerned about an absence of usual photographs in recent contact letters from the adoptive parents. The son's Social Worker explained as the son was now 18 years of age he was less likely to agree to photos and there was little social workers could do to influence this. Adult P could not be informed where he lived. This is recorded to have had a negative emotional impact upon Adult P for whom her son was a positive factor.
11th December 2013	Adult P was being troubled by unwanted callers who she felt simply came in to steal her money and her drink. The door was locked but they had never forced entry. Adult P admitted to HHCT she would let them in when she felt lonely and they were persistent but then she would regret it. She did sometimes ask these same men to fetch drink from the shop for her. Carers would also do this. Adult P had reported the men to the police in the past but did not want any police involvement at this stage. She said she had the strength to resist admitting them in the future. Adult P also had a nose bleed and the HHCT discussed with her the risk around reduced blood clotting when liver function diminishes because of alcohol dependency. Adult P declined to have a blood test performed. Her clothes appeared not to have been changed for some days. She was given repeat antidepressants and Vitamin B; but was not taking thiamine as she could not tolerate it. She was drinking approximately 8 cans, 9% lager daily. The plan was to discuss risks of her accommodation with other agencies.

20th December 2013	Adult P Seen at home by the HHCT. She had sufficient medication for 3 weeks and agreed to be weighed and have her blood pressure taken. She was drinking with an alcohol dependent male well known to services. Adult P stated she was not being coerced by him. He was asked to leave during the visit and he waited outside. It was discussed with Adult P whether she was able to prohibit ingress to these other drinkers if she kept the door locked and she acknowledged that they were largely out to exploit her but that they were also meeting her needs in going to fetch alcohol for her as she was less mobile. Adult P was deemed to have mental capacity regarding this decision. Professionals were at times fetching food and alcohol to Adult P. *It is not unusual for carers to support by obtaining alcohol and this can be part of the care plan.*
January 2014	Adult P allocated to new Social Worker.
3rd January 2014	Adult P advised HHCT that drinkers have been visiting her but that she does not want them in her flat anymore, aware that they were trying to steal from her and were drinking her alcohol. Evidence of mental capacity in Adult P's ability to retain the information about the risk these individuals present and make a decision. Does also have insight into the times when she has made unwise decisions and let them in because she feels lonely. Adult P given a further supply of medication, feels antidepressants may be helping to lift mood and wishes to continue. Has lost weight but claims she is eating. Adult P Does not want to go to hospital and refuses to see GP. HHCT outlined concerns to her.
6th January 2014	HHCT home visit in response to Society of St James carer who visited this morning and was concerned that Adult P seemed a little unwell. She declined to see a GP. It was clear she would not agree to hospital as she would not be able to smoke and drink. A neighbour was visiting at the time of the visit and Adult P reassured that she was comfortable with his presence. She did share with HHCT that her other visitor threatened her with violence and pulled a penknife on her (which she told a carer). A safeguarding meeting would be arranged. Adult P tells me that she is not letting that particular individual in.

14th January 2014	Review meeting held. *This was not a safeguarding strategy meeting.* Number of concerns discussed. Adult P allowing number of street drinkers into her flat. The meeting acknowledged Adult P is at risk of sexual and financial abuse. Meeting noted Adult P disclosed to her support worker one of these people had threatened to harm her with a penknife and threatened to withhold alcohol if she refused sex. - Meeting noted Adult P's mobility still impaired, unable access community unless assisted by support workers/carers - Increased self neglect - Started to drink whiskey - Poor living conditions and state of property Actions agreed: Social Worker to meet with Adult P and to review support package and contact Supporting People to discuss housing options and HHCT to discuss with Adult P referral to Independent Domestic Violence Advocacy Service. There would also be liaison with ML's landlord about maintenance issues and all agencies to continue monitor activities of Adult P's "guest."
15th January 2014	On arrival a carer from Society St James noted there was a man sleeping in Adult P's flat, but he got up and went out. Carer took Adult P to the shop to collect her money, encouraging her to buy food. Adult P also purchased whiskey. She said she would like a phone. HHCT agreed to source a phone for Adult P.
17th January 2014	Adult P seen at her flat feeling slightly better but continues to drink whisky as not able to tolerate strong lager. Carer continued to visit three times per week and Adult P aware that Care Manager will visit to review input and determine whether more time can be given on a weekly basis. HHCT discussed with her a visit by the IDVA (Independent Domestic Violence Adviser). Although initially cautious, Adult P signed a consent for this on the basis that the visit is to offer advice rather than oblige Adult P to do anything against her will. Demonstrated mental capacity in weighing the information given to her regarding this service and using the information to base her decision. Has sufficient medication for further 2 weeks I will visit with further medication then, feels omeprazole is helping and that anti-depressant is improving mood. Adult P declines blood test and review with GP and is able to give cogent reasons for this in terms of not wishing to engage in further treatment or be admitted to hospital. I believe Adult P has capacity but is making an unwise choice.

20th January 2014	Visit to Adult P by HHCT in response to carer stating that the door of her flat is wide open and no sign of her. Adult P was in fact in bed, sleepy but rousable. Limited amount of clothes on lower half and sign of faeces on her legs but declined to allow us to help her wash or change and asked us to leave. Stating that she does not know the time or the date and could not give us any reason why the door might be wide open. Carer advised that she would return in 2 days.
28th January 2014	Seen in basement flat by HHCT and an IDVA to advise about keeping safe. Adult P was able to be very honest with IDVA and agreed to have a mobile phone. Visited by one of the drinkers while we were there and IDVA was able to see for herself the difficulty presented as Adult P needed them to fetch alcohol from the shop and drawn towards the company as spends much of her time alone. As the meeting drew to a close Adult P had a seizure, full tonic clonic episode with loss of consciousness lasting approximately 60 seconds. Ambulance arrived while Adult P was in a post-ictal state but she regained consciousness abruptly after approximately 5 minutes. Adult P hospitalised but later self discharged.
31st January 2014	Seen at home by HHCT – has sufficient medication at present, is more intoxicated today and complaining that she had given one of the male drinkers money to buy her alcohol but that he had not returned. Adult P was very distressed by this. Review in one week.
5th February 2014	Review visit following hospital discharge. Care package increase discussed. Adult P happy with increase. Adult P said two males visited her, possible that others staying in her flat.
13th March 2014	Seen at Basement flat by HHCT. New sofa in place. Appears very thin- claims she is eating and looks bright in herself, encouraged to take Vitamin B. Continues to drink but seems to be back on strong lager no sign of spirits.
18th March 2014	Seen by carer - in good form. Claims she is eating a little bit more but still very thin.
26th March 2014	Adult P didn't change clothes, prompted again. Carer mopped floors (strong smell of urine). Adult P informed that known male visited. She said she felt threatened as she wouldn't give him and money.

27th March 2014	Carer stated Adult P was ok but also that she was rambling a bit about how humans are werewolves.
28th March 2014	Carer states Adult P quite tense today. Advised a few weeks ago known male came in and took all his clothes off in her room for sex. Carer called the Council about her rubbish outside flat to be removed and Went to shop for beers for her.
3rd April 2014	Carer states Adult P ok, made bed, swept and mopped floors. Adult P admits she urinates on the floor at moments. Carer made Home Support office aware to let all staff know when visiting to make sure they mop the floors on every visit.
7th April 2014	Adult P anxious and upset as she had not received any updates about her son. Social worker followed this up on Adult P's behalf.
8th April 2014	Carer states that Adult P has taken a sudden and vitriolic turn against staff. Very angry with Social Worker for son regarding provision of photos of her adopted son. Adult P hurt by fact that he appears not to want to engage now that he has reached 18 years of age. Does not want any staff to visit her or provide further medication.
10th April 2014	Social Worker contacted Society of St James and established situation settled and Adult P happy to engage with her usual support worker.
12th April 2014	Adult P appeared intoxicated though in a pleasant mood. Carer went to the shop to purchase 4x special brew and tobacco. All was well on departure.
15th April 2014	Carer tried to persuade Adult P to attend the Day centre to have a shower but she wasn't interested. She is described by carer to be in good spirits. Bedding was wet again. Adult P mainly just wanted to chat. All was well on leaving.
16th April 2014	Adult P noted to be quite confused.
17th April 2014	Adult P sat outside when carer arrived. Adult P was quite intoxicated. Carer changed bedding and mopped floors – strong smell of urine.
18th April 2014	On arrival by a carer from Society of St James the flat front door was unlocked and partly open. The door was jamming against the wall so Adult P had to come and pull it open properly. When she came to the door she was naked apart from a blanket draped round her back and over her shoulders. It looked like she had dried blood on her chest and stomach.

	When the carer entered into the room it looked like the place had been turned upside down. The carer asked Adult P what had happened and whether anyone had been in. Adult P had severe abdominal pain and looked particularly unwell. It was decided that she needed an ambulance so paramedics were sent. Adult P was admitted with severe abdominal pain requiring admission to General Intensive Care Unit with sepsis and ischaemic bowel. Paramedics alerted police as felt some evidence of sexual assault due to circumstances patient found in. Patient denied assault when asked. Shampoo bottle found in abdomen on x-ray thought related to assault patient unable to remember and stated she didn't want police involved. Hartman's procedure performed and removal of bottle from abdominal cavity and repair of large ragged tear in rectum. Patient transferred to ITU following surgery. Safeguarding alert raised by the hospital. Type of abuse suspected: Physical, Sexual, Neglect /Acts of Omission. Police attended patient's home address whilst ambulance crew were with patient to send an officer to seal the property later in the day. Decision taken following discussion with ED and ITU consultant that police should be informed about outcome of x-ray and patients poor condition. An internal safeguarding form was completed by Society of St James.
20th April 2014	Adult P died from her injuries two days later on 20th April.

8. Analysis

8.1 All reviews are required to take into account the risks of hindsight bias when making judgements regarding standards of practice. In this review it has also been especially important to be aware of the risk of 'outcome bias'. That is knowing the outcome of a case, can affect our judgement of the practice at the time as well as our judgements about what should be done differently in the future.

8.2 On analysis this SAR touches upon the following factors from which learning points emanate:-

1. **adult safeguarding;**
2. **self neglect;**
3. **consideration of mental capacity;**
4. **change resistant alcohol management**

Adult Safeguarding

8.3 The safeguarding system for adults pre April 2015 was informed by a national guidance document 'No Secrets', 2000 (reviewed 2009). The lead agency for safeguarding adults was and is the Local Authority who are a contact point for safeguarding alerts and referrals. Referrals generally come into a central point within the local authority, are considered on a case by case basis and then appropriate cases taken through a formal safeguarding process which necessitates a multi-agency strategy meeting and a formal plan on how to safeguard the individual.

8.4 The safeguarding process is a framework within which services can share what they know around the individual, share risk information, assess risk and take proactive steps to safeguard an adult at risk. The system is now placed on a legal footing with the provisions of the Care Act 2014. The danger of an informal or inconsistent safeguarding system is that professionals become unclear who is leading the process, where roles and responsibilities lie and the adult at risk may not be afforded the protection they require or should be able to expect under the adult safeguarding system.

8.5 Risk assessments were made around Adult P but these were limited in application as they were not multi-agency.

8.6 A self neglect thematic review for Southampton in 2016 concurs with this finding and this also found systemic challenges to the way that adults are safeguarded.

8.7 There is a great responsibility within law to protect adults at risk. The local authority were/are the lead agency and hold the responsibility for this working in partnership with other agencies. This includes those who self neglect and Adult P would be seen in that category now.

8.8 In "No Secrets", the broad definition of a 'vulnerable adult' was "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

8.9 The different forms of abuse were categorised under "No Secrets" as:-

- **physical abuse**, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;
- **sexual abuse**, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting;
- **psychological abuse**, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling,

intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;

- **financial or material abuse**, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
- **neglect and acts of omission**, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and
- **discriminatory abuse**, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

8.10 Adult P was exposed to a number of the above categories.

8.11 Under "No Secrets" agencies were required to adhere to the following guiding principles:-

- actively work together within an inter-agency framework
- actively promote the empowerment and well-being of vulnerable adults through the services provided;
- act in a way which supports the rights of the individual to lead an independent life based on self-determination and personal choice;
- recognise people who are unable to take their own decisions and/or to protect themselves, their assets and bodily integrity;
- recognise that the right to self-determination can involve risk and ensure that such risk is recognised and understood by all concerned, and minimised whenever possible (there should be an open discussion between the individual and the agencies about the risks involved to him or her);
- ensure the safety of vulnerable adults by integrating strategies, policies and services relevant to abuse within the framework
- ensure that when the right to an independent lifestyle and choice is at risk the individual concerned receives appropriate help, including advice, protection and support from relevant agencies; and
- ensure that the law and statutory requirements are known and used appropriately so that vulnerable adults receive the protection of the law and access to the judicial process.

8.12 Generally Adult P did not express herself to be a vulnerable adult though there were a few occasions when she acknowledged to professionals she was vulnerable to people exploiting her when coming to the flat. Adult P had several clear vulnerabilities relating to her health and social circumstances. In any event safeguarding is not based on the premise of self declaration.

8.13 The consequence of the safeguarding response for Adult P was risk was being managed at frontline service level (HHCT in the main) rather than by the lead agency managing the formal safeguarding process with full multi-agency information sharing and independent challenge and oversight. The accumulative impact of the incidents was not appreciated or managed effectively within the adult safeguarding system. Risk assessments were being made by the Homeless Healthcare Team but they lacked the multi-agency dimension that a strong safeguarding system and process can bring. The multi-agency safeguarding approach may have usefully drawn in other partner agencies e.g. community

policing who could have supported a community safety response to males going into Adult P's flat or any exploitation issues.

Finding 1

Adult safeguarding system - there was no form of statutory or other formal safeguarding process for Adult P. This left single agencies to manage a complex case.

Self Neglect

8.14 Adult P was not fully considered in the context of self neglect. In 2013 self neglect was not well recognised under the main adult safeguarding guidance - "No Secrets". Self neglect has emerged however as a real indicator of risk under the Care Act. For Adult P this was compounded by the belief that she always had mental capacity and therefore was simply making poor choices to self neglect and expose herself to risk. The guidance being used at the time was a 2012 document which is currently being revised. [7] The 2012 guidance emphasises risk assessment. It was not possible to find any formal recorded risk assessment for Adult P. There were some training materials of that time based on the research of self neglect by Professor Suzy Braye but it was unclear who knew about such training across the agencies or indeed who had received this. Further as the case did not progress to any formal safeguarding process self neglect was not considered in that context in terms of one of the risks being posed by Adult P. The current local guidance is 'Guidance on responding to Self Neglect and persistent Welfare Concerns 2016'.

8.15 Today, both Adult P's assessment of need and her care provision would need to meet the provisions of the Care Act 2014. This would include a risk assessment around self neglect.

8.16 The Care Act provides:-

A general duty on local authorities to promote an individual's 'wellbeing'. This means that they should always have a person's wellbeing in mind when making decisions about them or planning services.

Wellbeing can relate to:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation

[7] Southampton, Hampshire, Isle of Wight and Portsmouth City Council Managing Self-Neglect, Mental Capacity and Best Interests Guidance 2012

- the individual's contribution to society

8.17 Before the Care Act, individual users of services had different entitlements for different types of care and support. These were spread across a number of Acts some over 60 years old.

The Care Act replaces these and now provides:-

1. That the law focuses on the needs of individuals. The Care Act is based on the premise that the individual is always at the centre.
2. A clear framework to enable service users to better understand how the system works, and how decisions about them are made.
3. Law that is fair and more consistent, and removes anomalies that treated particular groups of people differently.
4. A clear legal framework for how local authorities and other parts of the health and social care system should protect adults at risk of abuse or neglect.

Finding 2

This case reflects the national context at the time of a lack of full understanding of self neglect and associated risks this poses to the adult at risk.

Mental Capacity

8.18 Adult P was judged to have mental capacity to make decisions and choices. HHTC and other professionals state they made mental capacity assessments of Adult P. Adult P's mental capacity was complex and multifactorial but this was seen in more narrow terms at the time. Whether a person has mental capacity to make decisions is a key factor to how they will be managed and the law seeks to protect those who lack mental capacity as they are inherently more vulnerable.

8.19 There was suspicion by clinicians at University Hospital Southampton that Adult P's cognitive functioning and memory were impaired. Agencies describe Adult P as presenting in different ways at different times. She could be hostile at times. Alcohol was a prominent factor and Adult P drank to excess which in turn may have altered her ability to understand information, retain it and weigh up choices.

8.20 Professionals understandably considered it inappropriate to assess Adult P's mental capacity when she was intoxicated, but even when sober there were indicators that her mental capacity may have been impaired by other factors. This review has concluded that not all the factors affecting Adult P's mental capacity were appreciated at the time and that the consideration of mental capacity assessments lacked formality. Fluctuating capacity can present challenges to professionals.

8.21 The Mental Capacity Act 2005[8] protects and supports those individuals who lack mental capacity and outlines who can and should make decisions on their behalf. The Mental Capacity Act covers important decision-making relating to an individual's property, financial affairs, and health and social care. The two stage test and principles of the Act are set out below:-

[8] Mental Capacity Act 2005, Code of Practice

The first stage is a diagnostic test:

1. Is there an impairment of, or disturbance in the functioning of the person's mind or brain?
2. Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

The second stage is a functional test. Can the individual:-

1. Understand information about the decision to be made?
2. Retain that information in their mind?
3. Use or weigh-up the information as part of the decision process?
4. Communicate their decision?

If a person lacks capacity in any of these areas, then this represents a lack of capacity (Mental Capacity Act 2005: Code of Practice).

8.22 The five principles of the Act are:-

1. The presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2. People must be given all appropriate help before anyone concludes that they cannot make their own decisions.
3. That individuals retain the right to make what might be seen as eccentric or unwise decisions.
4. Anything done for or on behalf of people without capacity must be in their best interest.
5. Anything done for or on behalf of people without capacity should be an option that is less restrictive of their basic needs - as long as it is still in their best interests.

8.23 The Court of Protection[9] has jurisdiction over the property, financial affairs and personal welfare of people who it claims lack mental capacity to make decisions for themselves.

8.24 The High Court[10] has powers under their inherent jurisdiction to protect adults who are vulnerable but who have capacity and are therefore outside the jurisdiction of MCA 2005 or lack capacity but it is not an issue that MCA 2005 covers. . The inherent jurisdiction can be exercised for vulnerable adults, with or without capacity, who are reasonably believed to be under constraint or subject to coercion or undue influence, or for another reason deprived of the capacity to make the relevant decision, or prevented from making a free choice, or from giving or expressing a real and genuine. If the person has capacity the court would need to weigh up the safeguarding risks with any interference of the persons human rights. The court will only invoke their powers if there is no other

[9] The **Court of Protection** in English law is a superior **court** of record created under the Mental Capacity Act 2005. It has jurisdiction over the property, financial affairs and personal welfare of people who it claims lack mental capacity to make decisions for themselves.

[10] The **High Court** is the third-highest **court** in the country. It deals with civil cases and appeals made against decisions in the lower **courts**. The **high court** is divided into three parts, which deal with different kinds of cases.

court process available and that the purpose of the application is not to overrule the wishes of an adult with capacity, but to ensure that the adult is making decisions freely.

8.25 More complex cases where there may be multiple factors impacting upon a person's mental capacity can be more challenging for professionals to assess. In some cases, mental capacity needs to be considered formally by a senior clinician weighing up all factors that may be impairing mental capacity. In these complex cases legal advice may be required as to whether the Court of Protection or the High Court may assist. This would be a step of last resort.

8.26 Whether an individual has mental capacity to make decisions defines how an individual is managed in the context of their finances, health and social care needs. An individual who is deemed to have full mental capacity may make unwise and what may seem irrational choices but they are entitled to do so. Those who lack mental capacity are managed using best interest considerations. Adult P was considered to have mental capacity at all times and making poor/unwise decision on lifestyle and health choices. However her mental capacity was more complex and not explored in any depth. There was also in the run up to her death aspects of risk around others entering her flat not always with her consent and exploitative elements emerging including concerns around sexual exploitation. This arguably impacted up her rights of autonomy and she expressed concerns around people entering the flat, taking money and not leaving when asked.

8.27 Further the concept of "executive capacity" is relevant where the individual has addictive or compulsive behaviours. This is explored by Preston Shoot and Braye et al[11]. This highlights the importance of considering the individual's ability to put a decision into effect (executive capacity) in addition to their ability to make a decision (decisional capacity)[12]. Therefore for an individual such as Adult P the assessment of mental capacity is unlikely to be as straightforward as a simple yes or no.

8.28 Professionals state they did assess Adult P's mental capacity on occasions, but there is no formal detailed record of this and how this was tested. From information before the review these lacked the requisite formality in terms of the depth of assessment and recording of this. There does not appear to also be any consideration of cognitive deficit due to chronic alcohol abuse or that possibly Adult P had fluctuating mental capacity. It would therefore seem that professionals thought they had fulfilled their duty to assess when actually a more detailed consideration was required.

8.29 It has been difficult to fully ascertain in the review to what extent Adult P's mental capacity was formally assessed in the community by those agencies who had contact. There are some references to mental capacity in records but no detail about whether a formal assessment was done, by whom, how this was tested or how conclusions were reached and in consideration of which factors.

[11] SCIE report 46:Self Neglect and Adult Safeguarding: Findings from research

[12] Naik 2008

8.30 Other relevant factors besides Adult P's alcohol addiction and intermittent depression were undue influence of those who appear to have been entering her flat exposing her to financial and sexual exploitation.

8.31 The discussions with the review team and frontline professionals as part of the review indicate that mental capacity assessments for more complex cases presents a real challenge across agencies.

8.32 Professionals appear much more comfortable applying a yes/no approach to mental capacity assessments but are less equipped to deal with more complex assessments or a fluctuating picture. Certainly not all professionals or agencies are aware of how factors such as duress or coercion can affect a person's mental capacity and that further expertise and/or legal advice may need to be sought.

8.33 Considerations around the Mental Capacity Act and its application have been raised within the Self Neglect Thematic Review completed in 2016. There is ongoing work in process to develop the self neglect toolkit and threshold; this is due to be completed mid-2019. Agencies and their professionals will need to consider mental capacity on a daily basis. Therefore recognising the more complex consideration for mental capacity and where to get help is key.

8.34 Recording and evidencing mental capacity assessments is good practice. Using the formal legal tests for assessing decisions provides a sound structure which teases out the individual's ability to make decisions. Without this structure, key factors influencing mental capacity may be missed and assessments become superficial. A full consideration, taking into account all relevant factors, informs professionals and services of options for intervention where appropriate.

8.35 A safe system equips professionals and services to appreciate that some mental capacity assessments can be incredibly complex, ethically and legally.

Finding 3

This case demonstrates an over reliance upon the assumption of mental capacity and the limits of understanding mental capacity in more complex cases. This includes where mental capacity may fluctuate. This impacts upon the professional's assessment of risk and what legal framework may be available to protect the individual.

Change resistant alcohol management

8.36 Substance abuse (drug or alcohol) is recognised as an important clinical disorder which can lead to significant cognitive damage as well as organ dysfunction and ultimately death. This can impact upon the cognitive ability to make decisions and the damage is accumulative over time where alcohol dependency is sustained. Adult P was signposted on several occasions to the alcohol services which were available at the time. This tended to be when she was attending hospital and there was no outreach alcohol service as such.

8.37 Without specialist input to complex cases with closer case management, frontline

professionals are left managing a high risk and complex individual with reduced prospects of positive outcomes around alcohol dependency. Those who present with change resistant behaviours present a particular challenge and the high degree of dependency raised risk and vulnerability considerably. This made Adult P more vulnerable in numerous ways around sexual and financial exploitation as well as relying on others to bring her alcohol when her mobility was significantly reduced by an injury. She was unable to always keep home and herself safe and secure.

8.38 The strength of the care pathway system for alcohol dependency also relies upon understanding developments nationally. There are sound nationally recognised programmes such as the Blue Light Project[13] which specifically targets those individuals who are alcohol dependent, including those who are not engaging with treatment or are change resistant. These national strategies should inform commissioners of services and be underpinning in planning accordingly, including outreach services.

8.39 Arguably also Adult P had a dual diagnosis as she experienced depression as well as alcohol dependency. However depression as a condition is not readily recognised as a significant mental health condition and yet depression can have a serious impact upon an individual and motivation. A dual diagnosis approach was not seen as relevant for Adult P. Further national care pathway guidance does not classify alcohol dependency and depression as dual diagnosis. Here the GP was managing Adult P's depression at a primary care level which is not unusual.

Finding 4

Agencies working with those who present as change resistant drinkers can usefully familiarise with national strategies to manage this. Commissioners of services should have recourse to the national strategies to plan services accordingly.

9. Good Practice

9.1 While the above represents learning and the need for better understanding and stronger systems to protect adults at risk, the persistence of some agencies to help Adult P must be acknowledged as good practice. The Homeless Healthcare Team continued to seek to engage Adult P.

9.2 Also there is good evidence that when Adult P was at the Emergency Department she was invariably offered and signposted to mental health and alcohol services to seek to support her in her underlying addiction.

10. Recommendations

10.1 The LSAB should seek reassurance from agencies on the implementation of the Multi Agency Risk Management Framework within practice.

[13] Holmes, M., & Ward, M. (2014). Alcohol Concern's Blue Light Project – Working with Change Resistant Drinkers.

10.2 Self neglect should be seen in risk terms rather than simply a likely matter of unwise choices. The LSAB should seek assurances from agencies upon the implementation of the revised Southampton self neglect policy to support an understanding of self neglect as a tangible risk if the individual has mental capacity or not.

10.3 The thematic review undertaken around the safeguarding system should be evaluated at this point to seek assurance that the system is now robust for complex adults and their risk assessment.

10.4 The LSAB is advised to ensure more training and support around the Mental Capacity Act and its application. Clear guidance is needed on when and how to document a formal and detailed assessment of capacity within case management when issues arise and are dealt with in real time and in fluid and complex situations. This should include comment in relation to what decisions one is assessing, including how to identify duress or coercion. It is not enough to simply record that a person has mental capacity.

10.5 Frontline professionals should be encouraged to seek support for complex cases from mental health and abuse services. This may involve a senior clinical specialist opinion, or a more comprehensive deliberation in partnership with other agencies. Professionals should know how to escalate concerns and be supported in difficult mental capacity assessments both clinically and legally where necessary.

10.6 The LSAB to reinforce with all agencies a positive reporting culture of safeguarding referrals for adults at risk. This brings holistic multi-agency risk sharing and supports a wider and more coordinated response including if necessary community police, environmental officers, landlords and outreach services.

10.7 The LSAB can usefully remind agencies that if concerns on any safeguarding response exists that there is a professional differences/escalation policy that should be used to escalate concerns.

10.8 The local “Guidance on responding to Self Neglect and persistent Welfare Concerns” 2016 merits a review and revision to take into account current research, case law and legislative interpretation of the Care Act and Mental Capacity Act.

APPENDIX 1

Terms of Reference

Reason for Review

Adult P was a vulnerable adult who was admitted to hospital on 18th April 2014 after an incident occurring at home. On April 20th 2014, Adult P died as a result of injuries sustained. A criminal trial identified that she was murdered.

Scope of the Review

The timescale of the review is 1st November 2013 to 20th April 2014. The timescale of the chronology is 01/02/2010 - 19/04/2014.

Review aims

- To examine the decision making processes and recording of information relating to Adult P.
- To examine whether **those** decision making processes took adequate account of Adult P's mental capacity to protect herself from abuse, neglect or exploitation.
- To identify whether Adult P could be considered vulnerable in line with Care Act guidance, and establish whether appropriate referrals were made to local safeguarding, health or social care agencies.
- If safeguarding referrals or referrals for social care needs assessments were made, were appropriate safeguarding procedures including risk assessments and protection/care plans in place.
- To identify any lessons to be learned from safeguarding or care management involvement with Adult P.
- To identify any recommendations arising from the care of Adult P that may inform the future development of LSAB or other local agency policies and procedures.
- To identify any areas of good practice.

The reviewer will ensure Adult P's next of kin has been contacted to inform them of the review taking place and allow them to contribute to the process and establish whether and how they want to be appraised of the findings when available.

APPENDIX 2 - Research references

- Care Act 2014
- Care and Support Statutory Guidance (2016) Department of Health
- Five Year Forward Review (2014) NHS England
- Holmes, M., & Ward, M. (2014). Alcohol Concern's Blue Light Project – Working with Change Resistant Drinkers
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- No Secrets-2000 revised 2009
- SCIE report 46: Self Neglect and Adult Safeguarding: Findings from research
- Statement of Government Policy on Adult Safeguarding (2013) Department of Health