Safeguarding Adults Review
Anna 2020

Independent Reviewer
Allison Sandiford

Contents

1 Introduction to the Case and Review Process

1.1 This review is in respect of a lady in her fifties to be known as Anna. Anna had a diagnosis of delusional disorder, alcohol misuse and associated brain damage, mobility problems, cirrhosis of the liver, inflamed pancreas, swollen abdomen, and incontinence issues. She had been known to adult social care (ASC) since 1997 but had significant multi-agency involvement since 2017. Professionals involved in the care of Anna were in ongoing disagreement in relation to Anna's mental capacity but in Spring 2020 the Court of Protection (CoP) made an interim declaration that Anna lacked mental capacity. Soon after Anna was admitted into hospital where sadly, she died within a few weeks.

1.2 The Safeguarding Adult Review Subgroup identified that the case met the criteria[1] for a Safeguarding Adult Review (SAR) as lessons could be learnt regarding the way that agencies work together to co-ordinate and oversee the care of a person who suffers mental health and substance misuse, and those whose capacity to make decisions is consequently affected by their dependency.

1.3 The review sought to understand the following key lines of enquiries:

- How had the use and understanding of the Mental Capacity Act impacted on safeguarding Anna?
- The provision of mental health support.
- How professionals had worked to engage Anna.
- How co-ordinated was the multi-agency planning and support and co-operation?
- Was there any recognition of the signs and indicators of exploitation/abuse/cuckooing?

1.4 LRSAB appointed an independent reviewer[2] who used a mixed method approach rooted in systems methodology and considered reports and chronologies provided by the agencies involved in Anna's care. Owing to Covid-19[3], the review's learning event was a virtual Table-Top Event with additional clarification of actions, and discussions/analysis held with the panel or identified practitioners.

1.5 The independent reviewer would like to emphasise that the purpose of this review is to consider what lessons can be learned to guide better future practice and to focus on opportunities for improvement within systems. It is not the purpose of this review to scrutinise the actions of, or apportion blame to, agencies or individuals. The review process has unavoidably been worked with the benefit of hindsight, but the report has attempted to minimise any influence of outcome bias.

[1] Section 44, the Care Act 2014 stipulates that Safeguarding Adult Boards must arrange a SAR when an adult in its area with care and support needs 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.
[2] The lead reviewer appointed was Allison Sandiford. She is an experienced reviewer and is entirely independent of the LRSAB.
[3] Covid restrictions in force at the time of the SAR necessitated the use of virtual communication.

1.6 The participation and opinion of family members of the deceased is an important aspect of the SAR process as their personal experiences of services provided to their relative proves invaluable. Sadly, the LRSAB was not aware of any family members able/willing to be involved in this process.

1.7 The review has considered agency involvement with Anna from autumn 2018, when a tenancy became available, until her death. There is some relevant information about Anna prior to this timescale which is summarised in this report due to it having relevance to later practice and/or decisions.

2 Brief Background and Synopsis of Events

2.1 Anna lived a life affected by neglect and abuse and possibly as a result became a substance misuser. Her relationships were dysfunctional and violent, and all of her children were removed from her care. Anna had a medical history of mental health issues and in 2018 she was detained for one month under the Mental Health Act due to presenting with delusional beliefs and the risk of self-neglect. After a month she was discharged from psychiatric hospital into residential care but due to her drinking, staff found her behaviour unmanageable. Anna stayed a week in an alternative residential care home before going to stay with friends. She was of no fixed abode until a suitable flat became available in a small country village. Her move was pending a package of care (POC) being in place.

2.2 In September Anna contacted ASC and disclosed that the friends that she was staying with were abusing her Due to these concerns the social worker (SW) co-ordinated for Anna to move into her new tenancy that same day; a POC was arranged with a home care agency and an ambulance transported her to the property.

2.3 Anna did not manage well on her own. She struggled to oversee her finances, address her care and health needs, and manage her alcohol misuse. She told the professionals who worked to support her, of problems with neighbours and the council received reports of her perpetrating anti-social behaviour. Throughout the scoping period of this review practitioners worked to ensure that an intensive support package was in place that would provide Anna with food parcels and shopping and ensure that she had her medication. This support effected frequent contact between Anna and professionals, but Anna did not always engage and was sometimes abusive to the point that carers had to leave the property.

2.4 Anna was subject of four safeguarding enquiries during the scoping period, two of which remained open at the time of her death. The enquiries related to an alleged sexual assault, conduct of carers and medication and alcohol being stolen by people coming into her home. Anna refused to give further details on each occasion, so the outcomes were unsubstantiated.

2.5 Because Anna displayed behaviours that caused professionals to question her capacity, she was assessed on 2 occasions under the legal framework of the Mental Health Act and 5 occasions under the Mental Capacity Act. Professionals differed in their opinion.

2.6 At a Vulnerable Adult Risk Management[4] (VARM) meeting following the outcome of the mental capacity assessment in April 2019, the agencies in attendance confirmed the concerns regarding Anna's capacity and it was agreed that the VARM process would end, and a safeguarding process would begin. As part of the protection plan Leicestershire County Council (LCC) would take on the role of Appointee to manage Anna's finances and organise her shopping deliveries. This would reduce Anna's dependency upon the people who allegedly abused her.

2.7 Over the next few months, the SW liaised with agencies around the details of the POC, medical appointments, support for Anna's alcohol misuse and the Appointeeship. In June 2019, she made a referral for an Independent Mental Capacity Advocate[5] (IMCA) but this was queried as it indicated that a change of accommodation best interest decision was not imminent.

2.8 Despite the intense support offered, Anna continued to struggle, problems persisted with self-neglect. Her engagement with Turning Point (TP) was poor and ineffective and there were times when she would not allow carers access. Anna continued to insist on a home detox stating that she did not want to go into hospital.

2.9 Anna continued to report issues with associates and in September 2019, she disclosed that people were taking her medication and alcohol, causing problems, and assaulting her. A subsequent MCA concluded that it would be in Anna's best interest if, in order to safeguard her, she was to be removed from her home and placed in a hospital to undergo alcohol detox. This required an application to the CoP. Via a remote court hearing the CoP made an interim declaration that Anna lacked capacity in relation to where she should live, her care, her treatment, contact with others and her financial affairs.

2.10 The first week in April 2020 Anna refused carers entry to the property. That same week the fire brigade forced entry and Anna was found on the floor following a fall. An ambulance was called and consequently Anna was admitted into hospital.

2.11 The hospital confirmed that discharge was distant, as Anna had serious and complex health issues, sadly Anna died.

2.12 During the scoping period Anna was supported by the following range of professional health and care services:

Professional / Agency	Acronym
Social Worker / Adult Social Care	SW / ASC
Carers from the home care agency	Carers
Doctor	GP
Borough/District Council	LBC
Leicestershire County Council	LCC
Turning Point	TP
Independent Mental Capacity Advocates	IMCA
Adult Mental Health Practitioner	AMHP
Community Psychiatric Nurse	CPN

[4] https://www.llradultsafeguarding.co.uk/self-neglect/#2_Vulnerable_Adults_Risk_Management

[5] The Mental Capacity Act 2005 introduced the role of the independent mental capacity advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

3 Analysis by Key Lines of Enquiries and Identification of Learning.

How had the use and understanding of the Mental Capacity Act impacted on safeguarding Anna?

3.1 The Mental Capacity Act is designed to protect people who may lack the mental capacity to make their own decisions about their care and treatment by empowering another person to make such decisions in their best interest. Anna suffering alcohol misuse and being mentally unwell did not automatically mean that she lacked mental capacity. Neither did any of her 'bad' decisions. Professionals demonstrated good comprehension of this and understood that the true test[6] to deciding whether Anna lacked mental capacity was to confirm whether she:

- Understood all of the information she needed to make a decision
- Used or thought about the information
- Remembered the information, and
- Was able to communicate her decision to someone else.

3.2 Any professional who became concerned that Anna did not have capacity in relation to making a specific decision, needed to confirm this by requesting or undertaking a capacity assessment. Until any assessment concluded that Anna was unable to do the above, she was treated as having capacity and supported to make her own decisions.

3.3 This review has seen evidence of good application of the MCA and on five occasions during the scoping period, concerns were raised by professionals about Anna's capacity to understand either her financial situation, the risks her relationships with certain individuals posed, or her ability to attend her care and treatment needs.

3.4 Consequently, assessments were undertaken, and Anna's mental capacity was well addressed. Assessments consist of two stages and as such any professional carrying out an assessment had to:

- Prove that Anna had an illness or injury that affected the way her brain or mind worked, and that
- It affected Anna so much that she was unable to make the specific decision at that certain time.

Professionals could only apply the second stage if Anna had been given enough support to try and make the decision for herself.

3.5 The first stage of the assessment is relatively easy to conclude as symptoms caused by Anna's alcohol use could be classed as an illness or injury affecting how her brain worked. However, the second stage could only be assessed by applying the test at 3.1 which is trickier as it is an issue of judgement. Taking these mechanisms of the assessment into consideration it is understandable how professionals, using the same evidence, can come to different yet valid conclusions and it is therefore defensible that professionals had different opinions regarding Anna's mental capacity.

3.6 There is no doubt that Anna's alcohol consumption frustrated the MCA process. Professionals at the Table-Top Event discussed how Anna could move in and out of capacity frequently according to her alcohol intake - meaning that the same professional could come to differing conclusions about her capacity on subsequent contacts within the same day. Assessing Anna totally sober was not an option as she would then be at risk of

[6] S3 (1), Mental Capacity Act 2005 c9.

seizures and other complications. As such the SW would attempt the assessments early in the day but even then, the first 15 minutes of a session could be taken up with Anna shouting her frustrations about needing alcohol. So complicated is the issue of mental capacity when working with a person who is dependent upon a substance, that the study 'Learning from tragedies: an analysis of alcohol-related Safeguarding Adult Reviews'[7] published in 2017, recommended that The Mental Capacity Act 2005 Code of Practice[8] should be amended to include specific guidance for working with individuals with alcohol misuse or dependence. It also recommended that national guidance should be produced on applying the MCA to people with fluctuating capacity due to alcohol misuse.

3.7 In addition to the alcohol frustration, professionals discussed how Anna was prescribed much medication that could also affect her mental state and the effects of such medication would have been amplified with alcohol.

3.8 It must however be acknowledged that even if alcohol and prescription drugs had been taken out of the equation, professionals still would not all have necessarily been of the same mind when assessing Anna's mental capacity. Considering that professionals saw Anna under different circumstances and under different specialities, it is expected that they each communicated with Anna differently and developed different relationships. Anna developed a good relationship with the SW and staff at the care agency, but she would have regarded those people as professionals who could provide her with the things what she wanted. This would have been reflected in her contacts with those people. Similarly, she may have demonstrated hostility towards other professionals who she did not consider 'helpful' to her cause and possibly towards new workers who she had only just been introduced to and hadn't yet gained any trust of. All of this would lead workers to form contrasting perspectives of Anna based upon their own experiences with her. In addition, practitioners would have had differing degrees of experience of applying the 'best interests' checklist in section 5 of the code of practice and subsequently varying awareness of ensuring that any personal belief and/or opinion did not affect any decision.

3.9 LCC spoke of recent training on a local level regarding the application of MCA. Lead practitioners in ASC have worked with Edge Training[9] to develop a new MCA assessment form and several 'How To' MCA Guides. There is not a specific guide for substance misuse, but there are guides around self-neglect and refusal of services which have relevance to this. The 'How To' guides were developed following feedback from staff requesting practical support with planning, structuring, and recording MCA assessments relating to different decisions. The associated MCA training programme for all Care Pathway staff began in September 2019 and is now almost completed in terms of live webinars. Recordings of these will be available going forward. LCC has also shared the 'How To' guides with the SAB for use on a multi-agency basis and the safeguarding board is offering a multi-agency 2-part MCA Masterclass: Fluctuating and borderline capacity in substance misuse and the MCA on dates in 2021.

3.10 Given the complications and vulnerabilities of the MCA, agencies should ensure that staff know where and who they can seek for advice, support and/or reflection both inside their own agency and out.

3.11 Where the SW, as decision maker believed that Anna lacked capacity, provisions under the MCA to identify best interest decisions were utilised. It is commendable that under this framework, professionals considered

[7] ACUK_SafeguardingAdultReviews_A4Report_July2019_36pp_WEB-July-2019.pdf
[8] The Mental Capacity Act 2005 Code of Practice provides statutory guidance for practitioners in applying the Act in practice.
[9] Edge provides training on specialist areas of health and social service law and practice.

a range of views and factors and although they did not always initially agree an action, they did reach consensus decisions.

3.12 Often a non-professional person who knows the person being assessed personally will be included in the MCA process, but Anna had no such appropriate person to consult about her care choices. In recognition of this and in line with good practice, when she was found to lack capacity about a decision, the SW made an application for an Independent Mental Capacity Advocate (IMCA). The first application was rejected because a 3-month domiciliary package of care was about to be trialled and therefore no change of accommodation decision was required at that time. (The second application in late 2019 was approved as decisions were imminent).

3.13 The IMCA Team can only be instructed at the time that a best interest decision needs to be made but in the absence of IMCA support being available, Anna would have been entitled to an Independent Advocate (IA) under Section 67 of the Care Act 2014. The role of an IA is similar to that of the IMCA in that it supports and represents people who do not have any appropriate other to do so, but it is broader and applies to a wider set of circumstances. Whilst an IMCA can only be instructed to work with people who lack capacity to make a specific decision, an IA will support an individual (with or without capacity) to understand information and to express their needs and wishes.

3.14 Age UK and POhWER[10] provide advocacy under the Care Act and IMCAs, and have just completed training with the IMCA service which explained the differences between an IMCA and an IA. The training has received positive feedback and could be shared amongst other agencies as it has been recorded.

3.15 The use of an IA was discussed at the Table-Top Event and it became clear that the SW had a good understanding of the IA and had offered one to Anna. The problem being that she hadn't accepted. Although, it is impossible to say whether Anna would have ever changed her mind about this, the benefit of re-iterating this support over time was discussed and agreed. It was also considered how the use of an IA may have had the effect of improving Anna's engagement with services and may have resulted in speedier intervention.

3.16 Anna's mental capacity was not relevant when she reported assaults by associates to the police, as the decision to prosecute is made by following guidance issued by the Director of Public Prosecutions[11] but the quality of her evidence was. Whether owing to alcohol consumption, her mental health or neither, Anna was unable to provide police with reliable evidence. She also made it clear that she did not support the police investigating further. In the event of being unable to prosecute, the primary aim of the police, and all agencies, had to be prevention. Which given that Anna was allowing her alleged perpetrators into her home and continuing to associate with them, led professionals back to the question of Anna's mental capacity - did she have the mental capacity to pursue her own safety? A police officer who is considering such a thing cannot record lack of capacity unless they have had specialist training to make that judgement. Instead, they should refer via the Public Protection Notice procedure.

3.17 As per good practice, the SW conducted an MCA regarding Anna's capacity to make a decision about who to have contact with. Professionals' conclusions differed with some being of the opinion that Anna had mental capacity, but all agreed that the risks were high enough to request intervention from the CoP. At first glance this application looks significantly delayed, but it was discussed at the Table-Top Event that the delay was actually in finding a suitable placement for Anna as you cannot go to CoP without a placement option.

[10] POhWER is a charity which helps people who find it difficult to express their views or get the support they need.
[11] Directors-Guidance-on-Charging-6th-Edition.pdf (cps.gov.uk)

Residential settings considered appropriate, informed the SW that Anna's alcohol use was too great, or that they could not support her physical condition. An alternative provision such as a detox placement was not an option as ASC do not fund them.

3.18 This SW spoke of how frustrating it is when there is no package of care to suit all of a person's needs and how the gap in provisions for people who misuse alcohol and suffer a mental illness is a real problem. Availability of a suitable placement for Anna would have resulted in housing/medical intervention happening sooner.

3.19 A Nurse Consultant working with the Dual Diagnosis Team suggests that a specific ward available for all patients receiving detox treatment in Leicester would be of benefit as opposed to patients being placed on different Leicester based wards. Local in-patient detox facilities are currently commissioned in Nottingham, but Leicester based patients cannot access the Nottingham service if they have unstable mental health problems.

3.20 In summary, professionals working within Leicestershire and Rutland, have access to a robust multi-agency procedure online resource to help them apply MCA, but assessing a person's capacity, particularly those who are affected by substance misuse, is such a complex area that professionals' opinions will often conflict and can slow the application of care. Although good MCA training is ongoing, there would be advantage to specific guidance/training being produced relating to assessing the mental capacity of a person who misuses substances, and to consideration of an MCA specialist champion being available to advise professionals within their own agencies. To compliment this all professionals should have a good understanding of what advocate services are available to individuals. Their services should be offered and utilised, where appropriate, in an attempt to help any person (with or without mental capacity) to understand and discuss their options with a neutral person not associated to any particular agency, discipline or service. Professionals' frustration is recognised in respect that where procedures are followed and a need for a residential service is identified, the availability of such a service remains a problem.

Recommendations:

1) ***Agencies must ensure that staff have access to guidance/training regarding advocacy services and understand the roles of, and eligibility for, an IMCA and an IA under the Care Act.***
2) ***Agencies must ensure that staff have access to appropriate professionals from whom they can seek advice, support and/or reflection of the MCA both within their own agency and others.***

The provision of mental health support.

3.21 The initial episode of care from the Mental Health Care Teams was prior to the scope of this review when Anna was admitted under a Section 2[12]. She was discharged after it had been assessed that she did not have an identifiable mental illness at that point and was not detainable. An MDT discharge plan was arranged to offer care and support care needs post discharge but because Anna had been discharged from secondary mental health services, the Care Programme Approach (a package of care that may be used to plan mental health care) was not considered.

3.22 The second episode of care was from summer 2019 when a referral was made to the Community Mental Health Team (CMHT). This referral was deemed to be routine as Anna had a social care package in place and was still using alcohol. In the autumn, the CMHT team lead advised the CPN to arrange a joint visit with the

[12] Mental Health Act 1983 (legislation.gov.uk)

SW. This was done but Anna did not engage, she said that this was because the visit happened in the morning instead of the afternoon.

3.23 Anna was assessed under the MHA in mid-autumn 2019. The assessment documented that Anna lacked insight into her delusional beliefs, however the outcome was for a treatment plan with antipsychotic medication in the community setting which Anna had agreed to. This outcome demonstrates the assessment principle of involving a person in decisions regarding their own care. Sadly, Anna proved unable to engage and manage a medication plan to address her delusional beliefs and her future engagement with the CPN was sporadic. However, good practice is evidenced by the use of a multidisciplinary team (MDT) approach by way of safeguarding meetings and joint working between the CPN and other professionals.

3.24 There is no evidence of a further assessment being considered under the MHA following Anna not managing her antipsychotic medication plan. The interface between the MHA and MCA was considered by a topic-specific working group as part of the Independent Mental Health Act review. The conclusion and recommendations of the working group were that in the case of inpatient admission and treatment for mental disorder, use of the MHA should continue to be based on whether a person is objecting to their admission or treatment, necessitating the use of compulsory powers. Given that Anna was not engaging with professionals and managing her medication, could a further MH assessment have been undertaken?

3.25 A further consideration is an impairment of executive functioning[13]. On occasions Anna presented in the assessment environment as being capable of weighing facts but later, she was unable to transfer those facts into her real-life everyday situation. For example, she was able to explain in assessment why she shouldn't let her neighbour into her home but would later let him in. The question that needed to be asked was 'is Anna making an unwise decision or suffering an executive functioning impairment?' This is not an easy question to answer as distinguishing between unwise decision making and executive impairment can be challenging. In unwise decision making, the person is aware but disregards certain facts relevant to the decision. In executive impairment, the person may not be able to access and integrate the correct pieces of information to make the decision at the time.

3.26 Williams and Wood (2017) highlight that an individual suffering an executive impairment are typically 'able to describe what they should be doing in logical terms when asked in the abstract, but in practice, fail to use this knowledge to guide their actions'. Put another way, they are good in theory but poor in practice. (Melanie George & Sam Gilbert).

3.27 In summary, mental health care was offered to Anna but the underlying challenge was that Anna struggled to engage and this struggle could not be overcome. Subsequently Anna's mental health was monitored within the community setting using wider MDT teams. This achieved a reduced risk in terms of the health and social care teams being aware in a timely manner when Anna presented with signs of deteriorating physical or mental health care concerns. In the absence of engagement and a legal admittance to a hospital setting, little else could be done as further support offered was declined. In the meantime, it is to the professionals' credit that they continued to work hard to engage Anna

[13] Executive functioning has been described by Mr Justice Cobb as *'the ability to think, act, solve problems, including the functions of the brain which help us learn new information, remember and retrieve the information we've learned in the past and use this information to solve problems of everyday life.'* An impairment of executive functioning impairment may be characterised by impaired social awareness and judgement and inflexibility/rigidity of thought and action leading to difficulty modifying behaviour as necessary.

Learning Points:

- ***Professionals must be satisfied that when depriving an individual of their liberty, for the purposes of providing care/treatment, they have authority. In the absence of consent that authority must originate from the provisions of the MHA or the MCA. When considering depriving a person of their liberty, both of these must be explored continuously and thoroughly.***
- ***Professionals should consider executive functioning when assessing capacity under the MCA. They should remember that individuals with an executive dysfunction[14] are able to demonstrate awareness into an issue that is being discussed within an assessment and plan around it, but might not be able to execute the plan in the real life situation. ('When mental capacity assessments must delve beneath what people say and what they do' by Dr Emma Cameron and James Codling[15] is a useful guide/introduction to assessing a person's decision-making capacity when they can seemingly 'talk the talk' but don't 'walk the walk'.)***

How professionals had worked to engage Anna

3.28 It was well known amongst the professionals that Anna had suffered much trauma in her life and professionals at the Table-Top Event talked about how everyone had conversations with Anna about addressing her past in the hope that this would help her to engage. Some managed to build a better rapport than others and gain some of Anna's trust, but engagement was still sporadic, and her past trauma was never able to be addressed. Dr Ressler[16], a professor in psychiatry, talks about how people who have experienced trauma may struggle with getting help[17]. *"One of the most common outcomes of trauma is avoidance,"* says Dr Ressler. *"It makes sense. If you experience something traumatic, you want to avoid thinking about it and going to places that remind you of it."*

3.29 In addition to this avoidance, people who have suffered trauma may face other challenges which restrict their ability to engage with professionals including stigma, how they view themselves, decreased quality of social interaction, subsequent poor mental health, anger and living with a substance disorder. It is also thought that some of Anna's problems with engagement stemmed from a constant flow of crises which occupied Anna's thinking and required immediate professional responses. This constant firefighting averted interactions and care planning.

3.30 Anna by refusing to engage with services which would mitigate harm[18], was self-neglecting and according to Braye et al. (2015), best practice for working with those who are self-neglecting is:

- to understand the individual's life history
- to strengthen practitioner-client relationships
- to use creative, flexible interventions
- to involve the individual
- to promote multi-agency working.

[14] An Impairment in Executive functioning skills is called Executive Dysfunction and is common after acquired brain injury. It has a profound effect on many aspects of everyday life.

[15] When mental capacity assessments must delve beneath what people say to what they do | Community Care

[16] Kerry J. Ressler, MD, PhD, is chief scientific officer and James and Patricia Poitras Chair in Psychiatry at McLean Hospital. He is also a professor in psychiatry at Harvard Medical School and past-president of the Society for Biological Psychiatry. Dr. Ressler's lab focuses on translational research bridging molecular neurobiology in animal models with human genetic research on emotion, particularly fear and anxiety disorders.

[17] Past trauma may haunt your future health - Harvard Health

[18] A person is defined as self-neglecting when they present with one or more of the following: • Lack of self-care, including hygiene, nutrition, hydration and health • Lack of care of one's environment, including squalor and hoarding • A refusal of services which would mitigate the risk of harm (Braye, Orr and Preston-Shoot, 2015: 2)

3.31 Much of this is echoed in the Making Safeguarding Personal (MSP) initiative. MSP, led by the Local Government Association Safeguarding Adults Programme and by the Association of Directors of Adult Social Services, aims to transfer emphasis from *'process'* to *'a commitment to improving outcomes for people at risk of harm'*[19]. MSP is about professionals seeing a person as an expert in their own life and working alongside them to improve their life by developing a real understanding of their wishes and desired outcomes and discussing how best that can be achieved.

3.32 MSP is evident within the care around Anna; several professionals working with Anna tried hard to understand and support her. The SW explained how she built a rapport with Anna and gained her trust. She said at the beginning of some visits there would be verbal hostility, but this could be overcome. Similarly, the care agency spoke of one particular carer who managed to develop a good relationship with her. Professionals included Anna in meetings around her care and her views were sought and respected as is exampled by the many provisions that were put in place to try and support Anna's wish to be treated at home. In addition, Anna's voice is evident in the MCA assessments.

3.33 But despite all of the professionals' efforts, Anna was still unable to engage and to overcome her self-neglect. Her ability to engage with support was hindered by her experiencing both substance misuse issues and mental health problems; the two problems exacerbated one another. Anna likely fell into an unconscious dilemma where she struggled to engage in support of one issue without having first addressed the other. Engaging a person such as Anna with these dual needs is difficult and could be argued to require some type of specialism.

3.34 The review has already considered professionals' attempts to support Anna with her mental health. In an attempt to support Anna with her alcohol misuse, professionals made referrals to TP. Several letters were sent to Anna offering her an appointment and visits were made to her address, but she refused to engage. TP is a substance misuse service which supports people to make change, but it requires the user to engage and commit. In an effort to connect with Anna, TP attempted joint visits with the SW; even offering alternative venues such as the GP surgery, but although Anna did sometimes allow staff into her home she didn't engage in any meaningful therapeutic work. Anna's experience highlights a gap in service for people who are unable to engage with services such as TP. This gap is recognised by TP and in an attempt to lessen it, TP remained available to other agencies to advise and continued to attend some meetings.

3.35 In addition, in summer 2019 TP made a referral to the dual diagnosis team which is a team that provides advice and support for substance misuse alongside monitoring mental health. The outcome of this referral is unclear, but it would have only proved effective with Anna's consent and engagement.

3.36 However uncomfortable, the question has to be asked whether professionals (outside of TP) had enough understanding of alcohol addiction in order to support Anna. There remains a stigma around alcohol misuse and the belief that it is a 'lifestyle choice' rather than a symptom and cause of other underlying issues. According to UK Rehab, *the reason there is such a stigma associated with alcoholism is that it is viewed as an overindulgence. A common stereotype is that alcoholics lack willpower, while wilfully engaging in bad behaviour.* They say *it can be difficult for individuals who have never been addicted to understand this loss of control...*

[19] 1.4 Making Safeguarding Personal – LLR SAB Multi-Agency Policies & Procedures Resource (llradultsafeguarding.co.uk)

3.37 This was explored with professionals during the Table-Top Event, and everyone was given an opportunity to share their views. There was a common consensus that all agencies recognised alcohol misuse as an illness and had training on the effects of alcohol but there was a need for more practical support for workers - withdrawal from alcohol is complex and care planning is far from straight forward. TP were pivotal to the conversations and discussed how they are happy to provide training on alcohol misuse to professionals and have much on offer, which it became clear was not widely known about and was not being employed to its full potential.

3.38 Professionals will also benefit from the *UK Guidelines on Clinical Management: Drug Misuse and Dependence* [20] otherwise known as the Orange Book, and guidance produced by NICE[21] re aspects of alcohol withdrawal and how to manage different levels of alcohol dependency.

3.39 Anna's fluctuating motivation made it difficult for professionals to engage her consistently with any plan. Alcohol Concern works with local authorities on a scheme known as the Blue Light Project which seeks to support hard-to-reach drinkers such as Anna who fit into three criteria:

- Alcohol dependent
- Burden on public services
- Non-engagement with treatment

The Blue Light project *challenges the belief that only drinkers who show clear motivation to change can be helped* and they provide courses to support the development of more effective working with people with co-occurring conditions and complex needs. Could agencies benefit from a proportionate number of staff utilising the programme and developing a specialism which could be used to further support colleagues?

3.40 In addition to Anna struggling to engage with professionals, her emotional and physical health conditions likely left her isolated from other members of society. And studies consistently show us that people who are isolated socially tend towards mental health issues and are more likely to abuse substances. Befriending is a popular form of volunteering in healthcare, and research suggests that it can be beneficial for people with mental illness. The benefits of a befriending service were discussed at the Table-Top Event and everyone agreed that this would have been a positive intervention. Unfortunately, at the time, a befriending service was not available to be offered to Anna. However, because a befriending service is an emotional support offering one-to-one companionship and not about assessing a person's capacity, it is thought that Anna may have engaged with this. Her developing relationship with one of the carer's evidenced her willingness to be friends with someone but whilst this relationship was positive, the carer's role must focus on functional activities. A befriending service allows a befriender and a befriendee to focus their relationship upon social and leisure activities. The effect of such a friendship could have decreased Anna's feelings of loneliness and lessened her need to spend time with those who were abusing her. If such a service had been available and offered when Anna first started her own tenancy, it may have encouraged her engagement with other services.

3.41 In summary, it is clear that LLR has good support available for people like Anna who are facing challenges, but engagement is essential. Whilst a befriending service may be of benefit, perhaps the most effective way for LRSAB to understand how to help people to engage effectively with their services is to seek the opinion of those that have already achieved some level of recovery.

[20] Drug misuse and dependence (publishing.service.gov.uk)
[21] Alcohol-use disorders overview - NICE Pathways

Learning points:

- ***Where appropriate and safe for both the provider and the receiver, consideration should be given to using a befriending service.***

Recommendations:

3) ***Agencies must be made aware of the Alcohol Misuse training provided by TP and ASC should ensure that workers understand and utilise the consultancy email support available from TP.***
4) ***The partnership should commission a piece of work that develops best practice by drawing on the experiences of interventions with people who have achieved a level of recovery to identify the support methods that are most effective. The findings should be disseminated multi-agency by way of a learning event or something similar.***

How co-ordinated was the multi-agency planning and support and co-operation?

3.42 There were multiple multi-agency meetings around Anna described by the professionals involved as strategy meetings, professional's meetings, best interest meetings, VARM meetings and safeguarding meetings. A recent SAR published by LRSAB has identified a confusion around the understanding of different multi-agency meetings and as a result, guidance has been created on the different types of meetings, roles and responsibilities and their framework.

3.43 Whatever the basis, it is good practice that the multi-agency meetings are convened as too often agencies work in silos and fail to share information or coordinate support effectively. But despite the meetings, it was felt that updates were not being shared effectively and the SW found it helpful to introduce an email chain with all the relevant persons included. This was agreed to have proven to be an effective way to manage the situation, particularly because Anna's situation was so chaotic with crises arising on sometimes a daily basis. Weaknesses of an email chain were recognised; Anna was not part of the chain, there is a danger of an email being missed, issues with confidentiality. It was also recognised that email chains should never replace the multi-agency meetings, but all professionals agreed that they had their place providing they were kept concise, confidential, and used appropriately. On the whole, common consensus was that the benefits of a real time response outweighed any negatives.

3.44 Because Anna was at significant risk but was refusing to engage with services the practitioners followed the VARM process. This was good practice. When it was agreed at a meeting that Anna's mental capacity was in question, the meeting concluded that the VARM process should end, and a safeguarding process commence under the categories of sexual abuse, financial abuse and self-neglect should begin.

3.45 ASC Senior Leadership Team, Learning and Development Team Leads and the Safeguarding Adults Lead Practitioner have developed a Signs of Safety (SOS) training model for use within Safeguarding Adults enquiries, with a focus on safeguarding meetings. Following attendance at the SOS Practice Leads training course, and in consultation with SOS consultants it was established by LCC that this approach, which was still primarily developed for use in work with children and families, would help develop a more inclusive and strengths-based approach to safeguarding adults' meetings. Subsequently in March 2020 a safeguarding meeting convened that utilised the model. The SOS framework, much in line with MSP, encourages a person-centred approach by fully involving the person and their social and professional networks in developing intervention plans to improve and promote their wellbeing. The chair of the meeting helps the attendees to

work together to map out the subject's situation and identify what needs to happen next. As per good practice, the safeguarding meeting involved Anna. Feedback from professionals at the Table-Top Event concluded that it proved to be a productive meeting. The risk scaling was noted to be particularly valuable in helping attendees to agree what the risks and perceived risks were and resulted in everyone, including Anna, agreeing on actions and measures to protect and support her.

3.46 The multi-agency meetings and the email chain assisted multi-agency communication but there were still some breakdowns in communication. When Anna first moved into her own tenancy a SW contacted her GP for advice around Anna's alcohol consumption but was told that Anna now needed to register with a new GP as she was no longer in their catchment area. Days later it was noted that Anna's address was still within the catchment area of her original GP after all. Anna changed GP regardless, but professionals were concerned that she had effectively been left without a GP practice for 10 days at a time when co-ordination of an effective care package was crucial for her future in the community setting. However, this review has been told that the mix up with the surgery's catchment area should have had no impact upon the care Anna received as the existing GP would have retained responsibility until the new registration had taken place. Since this review has started a statement has been issued to all GP practices reminding them of their contractual obligations when an individual moves out of the area.

3.47 As mentioned, Anna was receiving domiciliary care from a care agency. Staff became Anna's primary carers, calling on her three times a day and also completing two shopping calls each week. They assisted Anna with cleaning when she allowed, prepared food, fed her pets and of equal importance – provided Anna with regular social interaction. Carers have expressed that although they were kept in the multi-agency loop in many ways, they sometimes felt in dilemma; they had been told by agencies not to buy Anna alcohol but because they were seeing Anna on such a regular basis, they had to address the practical reality of the effects that no alcohol had on Anna. The care agency has said that clear guidance of how they were expected to support Anna in such situations and direction with regards to their provision of alcohol to Anna, would have been a big help. Other agencies agreed that documented confirmation of Anna's alcohol intake would have empowered carers and supported them as part of the multi-agency team around Anna.

3.48 Care agencies support people living in their own homes who present with a wide range of care needs including dementia, mental health needs, substance dependency, learning disabilities and physical disabilities. Although regular training will be provided through the care agency, staff are not usually qualified social workers or have any medical background and so it is especially important that they are fully supported and that workers from other agencies ensure that carers understand the package of care being provided and what is expected of them.

3.49 In summary, on the whole multi-agency systems were navigated well and with the help of the email chain, professionals were able to coordinate their support collectively. It is recognised that a disadvantage of the email chain is that it excludes the service user but use of the SOS model is proving effective in including the subject and its person-centred approach is in line with MSP. The concern that homecare providers are not always feeling fully supported to address a person's needs is a reoccurring theme that the reviewer is currently seeing in reviews nationwide.

Learning Point:

- ***Prior to closing a multi-agency safeguarding meeting professionals must all agree the best method of case communication to be used thereafter.***

- ***How to manage the practical response to a person suffering alcohol withdrawal, must be included within a multi-agency safety plan.***

Was there any recognition of the signs and indicators of exploitation/abuse/cuckooing?

3.50 LLR have multi-agency guidance regarding Adult Exploitations which includes cuckooing. It is regularly updated; informative and readily available online[22]. The guidance explains that criminal exploitation refers to organised gangs who take over the homes of vulnerable adults, either by force or by coercion, known as cuckooing. This was not the case for Anna; her home was not being used as a place for crimes to take place. Anna was a victim of crime perpetrated by her *friends.* Professionals working with Anna however, did recognise exploitation even though it did not meet the criminal threshold and it was good practice that a safeguarding enquiry was undertaken, and strategy and safeguarding meetings convened.

3.51 Anna and her associates were *friends* with common dependencies whose subsequent vulnerabilities and mental health issues made for a toxic association where arguments often resulted in physical assaults and opportunistic instants resulted in dishonesty offences.

3.52 There were numerous occasions during the timeline of this review when the risk to Anna from others was considered and six assaults were reported to the police. Police recorded the crimes but struggled to investigate as Anna would decline to make a witness statement or provide an account to the police officers. Without this, police did not have sufficient reliable evidence upon which to investigate. Anna was abusive to enquiring officers on many occasions and it is an example of good practice that officers returned and persisted in trying to follow up Anna's allegations. The possibility of any victimless prosecution was discussed at the Table-Top Event, but the threshold had not been met.

3.53 Anna viewed the people who were perpetrating crimes against her as friends and often chose to spend time with them and invite them into her home. Professionals witnessed them playing indoor games and drinking together. Subsequent intoxication would then result in incidents. In addition to Anna being victim to crimes, allegations were made against her by the friends, and other neighbours spoken to during enquiries said that things had escalated within the neighbourhood since Anna had moved in. They said that Anna caused the anti-social behaviours: both the police and the council received multiple reports of such behaviours. In summer 2019 housing served Anna with a Community Protection Warning. They felt that they had no choice at this time as there were so many community complaints and Anna was not engaging with any support to effect change. They also felt that Anna could not maintain her tenancy any longer and that the tenancy no longer served Anna's needs. All the professionals could see the toxicity within Anna's relationships, but Anna was unable to change her behaviour to keep herself safe and her mental capacity was again considered.

3.54 Mental capacity is crucial when safety planning with a vulnerable person and it was good practice that in September, when Anna disclosed to professionals that individuals were taking her medication and alcohol and assaulting her, the SW conducted a further MCA assessment in respect of the situation. Upon finalisation of the assessment in mid-autumn 2019, it was concluded that it would be in Anna's best interests to have contact with the individuals stopped. However, as previously discussed, a lack of a suitable alternative residential setting meant that nothing further could be physically done immediately. Consideration was given to issuing Anna and the *friend* written warnings but there were issues with both parties having the ability to

[22] LLR SAB Multi-Agency Policies & Procedures Resource – Multi-Agency Policies & Procedures Resource for Leicester, Leicestershire & Rutland Safeguarding Adults Boards (llradultsafeguarding.co.uk)

understand them and recall the conditions. If the other party had not suffered his own vulnerabilities and dependency then action could possibly have been taken which would have transferred the responsibility of no contact to him, but he was also thought incapable of understanding warnings and/or adhering to agreement.

3.55 In summary, although Anna's situation was not one that fit the description of cuckooing, there is no doubt that she was victim of crimes including assaults and theft. It is also undeniable that Anna's behaviours were anti-social and causing issues for the local community. Crimes could not be investigated as the demeanour and alcohol consumption of the parties involved resulted in a lack of credible or reliable evidence. Written warnings and/or court orders such as restraining orders would not have been effective for either party as neither had the capacity to understand and retain information, and likely, would not have had the ongoing inclination to adhere to the restrictions. Professionals were proactive in assessing Anna under the MCA and concluded with a beneficial best interest decision. Sadly, a lack of alternative residential provisions caused delay which prevented Anna being removed from her vulnerable and abusive environment.

Recommendations

5) ***The LRSAB Guidance for Working with Adults at Risk of Exploitation should be updated to include guidance for supporting adults at risk of exploitation when that exploitation does not meet the criminal threshold.***

Additional Analysis

3.56 A further interesting point which was mooted at the Table-Top Event was in relation to the geography of Anna's flat. Prior to the scoping period of this review Anna lived within a town environment. The flat that she resided in throughout the review period was of a country village location. Professionals spoke of village life possibly contributing to her poor engagement.

3.57 Anna had encountered issues when she lived in the town and she was now placed away from the area. Primarily this presents as a sensible decision, but she struggled to manage village life. The geography of living in a village means that amenities, even local ones, are usually located further away from a home than they would be if you lived in a clustered city or town. Walking was difficult for Anna due to her physical health and public transport and/or taxi services were not an option as she suffered from a variety of health issues. As a result, Anna was presented with an immediate barrier to attending any appointments outside of her home. This was additional to any inner emotional struggles that barred her engagement.

4 Good Practice

It is evident within the information provided for this review that there were many elements of good practice:

4.1 The social worker has consistently shown determination and commitment to co-ordinating a multi-agency response and support package for Anna and her extensive case notes reflect the efforts made to engage with Anna and the amount of activity undertaken. Her open reflection on the case and her willingness to partake in discussion in the Table-Top Event has proved an enormous help to the review author.

4.2 The police officers continued to follow up initial allegations and to ascertain facts despite Anna refusing to provide accounts and being abusive.

4.3 The GP practice provided Anna with a significant level of support and the GP went above and beyond his duty when he transported Anna to appointments and conducted regular visits to her home.

4.4 The carers provided a high standard of care to Anna towards the end of her life and developed good relationships with her.

4.5 The review has highlighted good consideration/use of MCA by professionals.

4.6 There has been effective use of the SOS model.

5 Conclusions

5.1 Anna was an unwell, isolated lady who struggled with addiction and was unable to meet her own care needs. She required support for her co-morbidity of issues which included mental illness, substance addiction and poor physical health. Professionals worked hard to support her but were hindered by her inability to engage and a lack of suitable resources.

5.2 Anna's non-engagement was the first hurdle professionals were faced with. Anna found it difficult to trust and it took time to build a rapport with her. Some professionals were more successful than others but the chaos in her life, that she then shared with trusted workers, left them constantly firefighting crises, and further hindered any progress. Anna had no one else to support her – she was not in contact with any family and had no positive friendships. The geographically isolated location of her accommodation was recognised as a further barrier to engagement and increasing her isolation.

5.3 Commendably Anna's mental capacity was under consideration throughout the timescale of this review. Professionals recognised that whether Anna had mental capacity to make a decision defined how she was supported to manage her finances, her associations and her treatment. And that whilst she was deemed to have capacity, she was entitled to make unwise decisions regarding all of the above. Discussions at the Table-Top Event indicated that professionals were comfortable with the MCA process but less confident when considering complex capacity assessments such as Anna's where substance misuse presented them with a fluctuating picture. Frontline practitioners should be encouraged to seek support for cases such as this.

5.4 Sequential treatment for Anna's mental health and substance addiction was not possible as she was excluded from some mental health services because of her substance misuse and vice versa. In addition, both disorders were of such a severity that neither could be prioritised. Some method of parallel treatment was the only option. Anna insisted that she did not want to be admitted into a hospital and that she wished to detox at home. Many provisions were put in place in an attempt to support Anna to stay at home, but none proved successful.

5.5 Following Anna being deemed to lack capacity she was managed using 'best interest' consideration, and care planning away from her home could now be considered. However as when trying to support Anna at home, her dual diagnosis proved a problem and no suitable residential setting able to address her mental/physical health and her alcohol addiction, was found. The care pathway for people with a dual diagnosis is insufficient in respect that it lacks specialist input, case management and residential support.

5.6 In summary, Anna's circumstances were complex and chaotic. Professionals showed multi-agency persistence and commitment to Anna and utilised the support that was available to them. Despite Anna being unable to engage meaningfully, their approach was person centred and they afforded a thorough monitoring presence.

6 Learning Points and Recommendations

6.1 This review has highlighted the following learning points for LRSAB and its partner agencies:

- Professionals must be satisfied that when depriving an individual of their liberty, for the purposes of providing care/treatment, they have authority. In the absence of consent that authority must originate from the provisions of the MHA or the MCA. When considering depriving a person of their liberty, both of these must be explored continuously and thoroughly.
- Professionals should consider executive functioning when assessing capacity under the MCA. They should remember that individuals with executive dysfunction are able to demonstrate awareness into an issue that is being discussed within an assessment and plan around it, but might not be able to execute the plan in the real life situation.
- Where appropriate and safe for both the provider and the receiver, consideration should be given to using a befriending service.
- Prior to closing a multi-agency safeguarding meeting, professionals must all agree the best method of case communication to be used thereafter.
- How to manage the practical response to a person suffering alcohol withdrawal, must be included within a multi-agency safety plan.

6.2 This review makes the following recommendations for LRSAB and asks that it seeks assurance from the appropriate agencies that they be addressed:

1) Agencies must ensure that staff have access to guidance/training regarding advocacy services and understand the roles of, and eligibility for, an IMCA and, an IA under the Care Act.
2) Agencies must ensure that staff have access to appropriate professionals from whom they can seek advice, support and/or reflection of the MCA both within their own agency and others.
3) Agencies must be made aware of the Alcohol Misuse training provided by TP and ASC should ensure that workers understand and utilise the consultancy email support available from TP.
4) The partnership should commission a piece of work that develops best practice by drawing on the experiences of interventions with people who have achieved a level of recovery to identify the support methods that are most effective. The findings should be disseminated multi-agency by way of a learning event or something similar.
5) The LRSAB Guidance for Working with Adults at Risk of Exploitation should be updated to include guidance for supporting adults at risk of exploitation when that exploitation does not meet the criminal threshold.

The Leicestershire &Rutland SAB (Safeguarding Adults Board) and Partner agencies have prepared action plans which describe the actions that are planned to strengthen practice in response to the learning from this safeguarding adult review

A 7 Minute Briefing (Appendix 1) has been completed to share learning through agency publications, training and supervision.