Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

Safeguarding Adults Review

Amanda

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SAFEGUARDING ADULTS REVIEW – Amanda

Lewisham Safeguarding Adults Board

1. Background to Amanda's Life, and Her Care and Support in 2018-2019

1.1 Amanda was a white woman who was born and grew up in southeast London. She died in 2019.

1.2 In May 2019, at age 57, she had been living for two years in a Care Home in Lewisham. The Care Home is registered to support up to 14 adults with mental health and substance misuse issues. Staff at The Care Home provided Amanda with 24 hour care and support.

1.3 As a child Amanda showed early artistic promise through her drawing. After leaving school, Amanda attended art school. She became a talented painter.

1.4 At a young age, doctors had diagnosed Amanda with paranoid schizophrenia. Today, her family are uncertain about whether that was a sufficient or accurate description of all her mental health needs. A family member recalled that sometimes the term personality disorder[1] was discussed. Another wondered whether Amanda might have been autistic.

1.5 Amanda developed a dependence on drugs and alcohol. She used different substances at different times in her adult life.

1.6 In 2018-2019 Amanda was receiving mental health care coordination from South London and Maudsley NHS Foundation Trust (SLaM). The services she received were an integrated service with the London Borough of Lewisham's Adult Social Care service.[2] Her care was managed under the Care Programme Approach (CPA)[3] and she had an allocated mental health care coordinator. As someone who had both schizophrenia and substance misuse, she was treated for her dual diagnoses. As she had previously been detained under a section of the Mental Health Act 1983 (amended 2007), her ongoing care and support was funded under the aftercare provisions of the Act.[4]

[1] The term "personality disorder" is used to describe a range of types of mental distress. Nowadays there is a growing movement to use different descriptors that illustrate how an individual's experiences may be a response to the psychological impacts of complex trauma, particularly in early childhood.

[2] The acronym SLaM is used throughout to refer to the integrated service that Amanda received from South London and Maudsley NHS Foundation Trust and Lewisham Adult Social Care.

[3] The term Care Programme Approach (CPA) describes the approach used in mental health services to assess, plan, review and co-ordinate the range of treatment, care and support needed for people with complex care needs in contact with statutory mental health services.

[4] Some people who have been detained in hospital under the Mental Health Act 1983 (amended 2007), have their aftercare funded under the provisions of s117 of the Act.

1.7 Amanda's schizophrenia was treated with medication, administered by regular depot[5] injections. Amanda had not always been compliant with her anti-psychotic medication, but at the time of the review she was settled into a routine of accepting her depot injections. Her mental health was stable and had been for some time previously. In 2018-2019, Amanda's alcohol use was the more significant issue.

1.8 When Amanda first moved into The Care Home in May 2017, she was recovering from a leg injury after a fall. She had been detoxed of alcohol during her hospital admission. The injury restricted her mobility, and she was unable to go out to buy alcohol.

1.9 As her physical health improved and she became more mobile, she resumed consuming alcohol. In 2018-2019, Amanda was regularly drinking large amounts; mainly vodka, but also gin and whisky. She was making efforts to reduce her alcohol intake, and she was achieving this intermittently, which was evidenced in tests that alcohol support practitioners carried out with her. She hoped to attend a residential detox placement to begin further rehabilitation. Planning for this was underway, directly with Amanda and to agree the placement funding.

1.10 Amanda's dependence on alcohol had caused her much trouble over the years. In earlier times, the circumstances of her life meant that her two children were unable to stay with her. They were adopted and cared for by Amanda's sister. Nevertheless, Amanda was able to remain part of her children's extended family life.

1.11 In 2016 Amanda was diagnosed with Hepatitis C, and she was treated successfully during the period of this review. This was an important intervention as her liver function would already have been compromised due to her heavy alcohol consumption. Untreated Hepatitis C would have impaired her further.

1.12 Amanda smoked cigarettes, a cause of further potential health problems and a fire risk when she was under the influence of alcohol.

1.13 Latterly Amanda had several health conditions including some that were associated with her history of smoking and heavy drinking. Her physical health challenges included significant mobility problems due to osteoarthritis and swelling in her legs caused by excess fluid accumulation (oedema). Amanda made use of a walking stick and walking frame to help her walk.

1.14 During the period of this review, Amanda was in regular contact with her GP practice who attended to the wide range of her physical, mental health and substance use needs, prescribing medication and liaising with secondary care clinicians, and the wider professional network supporting Amanda.

[5] A depot injection uses a liquid that releases the medication slowly so that its effects last longer. It is commonly used for anti-psychotic medication.

1.15 When she was intoxicated, Amanda was susceptible to falling and sustaining injuries including head injuries. Her falls seem to have been caused by losing her balance when intoxicated. There were also a few occasions when it appears she had a seizure of some sort. She could become doubly incontinent when heavily drunk.

1.16 The police were often involved in responding to reports of her intoxication in public places. She was regularly transferred to hospital emergency departments by the London Ambulance Service and others.

1.17 While living at The Care Home, Amanda socialised with other residents. She was known to travel to Brighton from time to time to meet up with others. In 2018-2019 some of her social life revolved around street drinking groups in Lewisham.

1.18 On 15 May 2019 Amanda didn't return to The Care Home. Care Home staff informed the police that she was missing.

1.19 Amanda did sometimes go missing for short periods of time. On this occasion, when she didn't return quickly, family members began their own enquiries, concerned about the lack of progress in the police investigation. These family enquiries led to new information about what might have happened to Amanda. Family members then shared this with the police Missing Persons Unit. The police responded by searching an unused garage in the borough.

1.20 The garage was derelict and along with adjacent garages was due to be demolished as part of a redevelopment programme. It had been used by street people to leave or dispose of belongings. It had also been used as a rough sleeping site. To stop this activity, Lewisham Homes had boarded up the garage entrance in May 2019. Lewisham Homes' records do not identify the exact date that this work was undertaken.

1.21 On 5 July 2019 the police found Amanda's body in the back of the garage. She had been missing for just under two months. At the time of the completion of this review, the cause of Amanda's death had not yet been established.

1.22 Lewisham Homes' usual practice is to clear or undertake an inventory of belongings before garages are secured. In this instance the rubbish and detritus in the garages made a full inventory impossible, and a decision was made to delay clearance of the garage until it was demolished.

2. Methodology

2.1 This Safeguarding Adults Review has examined the circumstances of the care and support that Amanda received during 2018 and in the months in 2019 until her disappearance in May 2019. To provide some context, this report has also included a little background detail about her earlier life.

2.2 The reviewer and author of this report is a retired adult social services and NHS manager with previous experience of reviewing serious untoward mental health incidents, including deaths.

2.3 She met individually with Amanda's sister, and their mother.

2.4 She visited The Care Home to talk to the manager of the care home.

2.5 She received and analysed Individual Management Reviews (IMRs) from agencies that had been involved in providing care and support to Amanda.

2.6 They are

Service Name	**Service Received**
The Care Home	Amanda's home in a care home, registered to support adults with mental health and substance misuse issues, providing care and support over the 24 hour period.
Change Grow Live (CGL) – New Direction	Key work services and group work with the aim of Amanda accessing residential detoxification and rehabilitation for her alcohol use and preventing relapse. Amanda also received assessment by medical staff in times of crisis.
Lewisham & Greenwich NHS Trust – University Hospital Lewisham and Queen Elizabeth Hospital	Assessment and treatment following emergency health needs and minor injuries; including five inpatient admissions during the period under review.
London Ambulance Service NHS Trust	Assessment and conveyance to hospital Emergency Departments.
South London and Maudsley NHS Foundation Trust (SLaM) which included integrated services from the London Borough of Lewisham Adult Social Care	Mental health care coordination including medication administration by depot injection. Amanda also attended the Lewisham Active Recovery Community (LARC), a group that was run by mental health professionals to support people who draw on services.
The GP Surgery	General Practice support for a range of health conditions.

2.7 Other contributors to the review were

- The Care Quality Commission (CQC), who regulate care homes, and in this context inspect and regulate The Care Home.
- The NHS and Local Authority Joint Commissioners of services at The Care Home, who carried out regular monitoring of the care home.
- The Metropolitan Police Service.

2.8 Agencies involved with Amanda supplied chronologies of their involvement with her. During the period of this review Amanda had numerous contacts with the services in Lewisham listed at 2.6 above, as well as the Metropolitan Police. Each agency has supplied summary records of each contact with Amanda, and exchanges of information between agencies as they collaborated to manage the unfolding circumstances relating to Amanda.

2.9 Some of these agencies were asked for some more detail to supplement their chronologies.

2.10 The reviewer chaired an event on Microsoft Teams attended by all the agencies listed at 2.6 and 2.7; except for the CQC who sent their apologies.

3. Safeguarding Adults Review

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

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

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

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

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

The SAB may also –

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

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –

a) identifying the lessons to be learnt from the adult's case, and

b) applying those lessons to future cases.'

3.2 Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (Section 44 (5), Care Act 2014).

3.3 The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Adult Safeguarding Policy and Procedures. These are reiterated in Lewisham Safeguarding Adults Board Safeguarding Adults Review Policy & Procedures.

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

3.5 This case was referred to the LSAB on 16 January 2020 for their consideration of a Safeguarding Adults Review by London Borough of Lewisham – Adult Social Care – Safeguarding & Quality Assurance Team.

3.6 The LSAB assessed the case at their meeting on the 20 October 2020, where it was decided that they would like to review the care and support received by Amanda prior to her death.

3.7 The board decided that this case did not meet the criteria for a mandatory Safeguarding Adults Review as in Section 44 of the Care Act 2014. But the care and support provided by Lewisham Agencies to Amanda prior to her death would benefit from review. The board further advised they would like to exercise their option under Section 44 (4) to review any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

3.8 The agencies involved in the Safeguarding Adults Review were approached formally in October 2021. This was a time when many services were continuing to adjust to the significant ongoing workforce and operational challenges of the Covid-19 pandemic. Against this background context, the review was slow to get underway. Some of the agencies who were involved in the care and support of Amanda delayed in submitting their written responses and the reviewer was not able to begin the review until these were complete.

3.9 It is of note and concern that a very short document from the Care Quality Commission took them six months to submit. This was despite many prompts and reminders.

4. The Evidence Base and Legislative Context That Governed Amanda's Care and Support

4.1 Amanda's care was organised by the State, and in this context, she had rights as a user of these services. Each agency had responsibilities to ensure that her care and support was steered by relevant practice guidance, regulation, and law.

4.2 Amanda had been a community patient of SLaM for many years. She had in earlier times been detained as an inpatient under the Mental Health Act 1983 (amended 2007). She then received aftercare services under s117 of that Act. At the time of this review her care and treatment was being coordinated under the Care Programme Approach.

4.3 In terms of law and regulation, Amanda's care and support was assessed and commissioned within the terms of the Care Act 2014 and the aftercare provisions of the Mental Health Act 1983 (amended 2007). The London Borough of Lewisham was responsible for her adult social care services, and SLaM were responsible for her secondary and community mental health care.

4.4 Amanda's placement at The Care Home was commissioned on behalf of the integrated health and social care service at SLaM. The Care Home is regulated and inspected by the CQC. Lewisham's Joint Mental Health Commissioners monitor the quality of provision through their Contracts and Quality Assurance Team. The home was not inspected by the CQC during the review period. A 2016 CQC inspection reported that the home was Good in all the inspection domains. Lewisham's Contracts and Quality Assurance Team undertook monitoring in May and June 2018.

4.5 During the period of this review Amanda was a regular attender at her GP practice and local hospitals. She also attended NHS dental services.

4.6 Each of the organisations that Amanda received services from had duties under the Equality Act 2010 requiring attention to be paid to all protected characteristics.

4.7 Amanda's capacity to make decisions was known and regularly observed to be severely compromised when she was intoxicated. That meant that consideration had to be given to her decision making capacity and her executive functioning within the terms of the Mental Capacity Act 2005, its Code of Practice and practice guidance. What is meant by executive capacity is Amanda's ability to follow through on stated intentions by planning and actions. The National Institute for Health and Care Excellence have published guidance on this issue – NICE Guideline NG108 (2018) *Decision-making and mental capacity* (London).

4.8 Amanda's safety and wellbeing were known to be at risk, both in terms of potential self-neglect and danger of financial, sexual and physical exploitation and harm from others. This meant that the safeguarding provisions of the Care Act 2014 applied to her circumstances. Practice and policy documents such as Making Safeguarding Personal and the London Multi-Agency Adult Safeguarding

Policy & Procedures were highly relevant to her life during the period of this review.

4.9 Advocacy support for people involved in safeguarding procedures is key to supporting individuals to consider how to best support themselves to be safe in their lives.

4.10 In the review period, Amanda's primary needs related to her significant alcohol dependence and the risks this posed to her wellbeing and survival. There is guidance available to practitioners to support people who have co-existing mental ill health and substance misuse. See for example:

- Public Health England/National Health Service England (2017) – *Better care for people with co-occurring mental health and alcohol and drug use conditions* (London)
- NICE - NICE Guideline CG115 (2011a) - *Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence*, (London)
- NICE - NICE Guideline CG120 (2011b) - *Psychosis with coexisting substance misuse,* (London)
- NICE – NICE Guideline NG58 (2016) – *Co-existing severe mental illness and substance misuse*, (London).

4.11 Each of the services that Amanda drew on listed at 2.6 above, including her General Practice and Change Grow Live (CGL), deliver services in a regulatory and evidence based context, drawing on the legislation and guidance mentioned above, as well as on a wider range of clinical and policy guidance.

4.12 In 2021 Alcohol Change UK published *How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales*. This document, authored by Professor Michael Preston-Shoot[6] and Mike Ward, sets out a range of legal options, as well as suggested governance structures to support people who are vulnerable because of their significant alcohol dependence. Although this Alcohol Change UK report was published well after the events leading up to Amanda's death, it does reference legislation and guidance that was in place and widely used in 2018/19.

5. Thematic Analysis and Findings

5.1 The report *How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales* sets out several frameworks for making the best use of legal powers when working with chronic, highly vulnerable, dependent drinkers such as Amanda .[7]

5.2 A key question in this Safeguarding Adults Review is whether agencies took sufficient steps to weigh up whether more restrictive options should have been

[6] Professor Michael Preston-Shoot is also the Chair of Lewisham's Safeguarding Adults Board.
[7] See Section 5 Practitioner approaches for using legal powers in Preston-Shoot, M. and Ward, M. (2021) How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales. (Alcohol Change UK)

considered to mitigate the serious risks to life and limb that Amanda was experiencing in 2018-2019.

5.3 One of these frameworks in the Preston-Shoot and Ward report offers a four-stepped process where practitioners can increase their interventions in the light of their experience of working with the individual.

Image courtesy of Alcohol Change UK

5.4 **Step A** involves individual agencies trying to support the individual.

5.5 There were important successes with Amanda during 2018 and 2019.

5.6 Amanda's family say that Amanda's stay at The Care Home had been less troubled than many other previous placements and housing arrangements. Communication between The Care Home and Amanda's family was good. The psychiatrist responsible for Amanda's care concurs with the view that this placement was working better for Amanda than some other earlier placements.

5.7 There are no explicit references to equalities issues in the records, other than her gender; nor references to any faith based or cultural needs. However, there are many examples in the records of practitioners responding to Amanda in considerate and thoughtful ways, acknowledging and engaging with her mental and physical health disabilities resulting from a long history of mental distress and substance misuse. The Care Home report that she participated in

the communal life in the home including celebrations. From time to time she met with her family members in their homes.

5.8 Amanda was receiving care and support in line with national guidance in relation to people with mental illness and substance dependency. Amanda was actively considering a residential detox placement that might have begun a new chapter in her life. The agencies working with Amanda were planning this placement with her and with the commissioners who would fund the placement.

5.9 Amanda had been referred to and was making use of two services that had supported her with her mental health problems and her substance misuse: CGL and Lewisham Active Recovery Community (LARC). At CGL she had one to one support and group work to plan for her accessing residential detoxification and rehabilitation for her alcohol use and helping her to prevent relapse. At LARC she participated in group work with others in the community who were living with mental health challenges.

5.10 During the period of this review Amanda had several health conditions that were associated with her history of heavy drinking. Amanda was in regular contact with her GP practice who attended to the wide range of her physical, mental health and substance use needs, prescribing medication and liaising with secondary care clinicians, and the wider professional network supporting Amanda.

5.11 She was also receiving hospital-based services such as orthopaedics, gastroenterology, and hepatology, including the treatment for her Hepatitis C. She also received services from the community dietitians.

5.12 Her lifelong use of substances had impacted on her physical health and the records show that this was being assessed and monitored in a variety of ways by health professionals and staff at The Care Home. The aim was to reduce the negative impact of alcohol on her body and to help her sustain and improve her nutrition.

5.13 During the period of this review Amanda's alcohol use and alcohol dependence was the dominant issue of concern. She was trying to reduce her alcohol intake. The Care Home did engage Amanda in some harm minimisation strategies. Intermittently Amanda was reducing her alcohol intake, which was evidenced in tests that alcohol support practitioners at CGL carried out with her. She hoped and was planning to attend a residential detox placement to begin further rehabilitation. (The option of a community detox, delivered in The Care Home had been discounted as Amanda's detox needed close medical supervision.)

5.14 The records of The Care Home's involvement with Amanda during her time with them identified risks of:

- Alcohol abuse
- Relapse of her mental health condition
- Falls, exacerbated by heavy consumption of alcohol
- Self-neglect

- Fire risk due to smoking in the premises
- Incontinence
- Sexual exploitation
- Financial exploitation.

5.15 The good work that was taking place with Amanda addressed many of these concerns; set out in her care and treatment plans and delivered in practice.

5.16 However, Amanda continued to experience recurrent very significant danger from falls and violence.

5.17 Amanda sustained repeated injuries. She often fell in public places including on roads. A road traffic accident could have been fatal; as could a head injury from a fall. She lost possessions in the street and sometimes she would report that she had been robbed. Some of her injuries and bruising were suggestive of assault. This should have led to some inquiries around domestic abuse, but these do not appear to have been made routinely; and on the occasions that they were, it is reported that Amanda did not want to engage in the discussion. Generally, Amanda was unwilling or unable to give accounts of how her injuries had been sustained.

5.18 During the review period Amanda attended the Emergency Departments at University Hospital Lewisham and Queen Elizabeth Hospital on 73 occasions. She had three admissions to Queen Elizabeth Hospital and two admissions to University Hospital Lewisham.

5.19 Most of Amanda's contacts with hospital based services were for alcohol intoxication, falls and injuries associated with those falls. At least 55 of her attendances at the Emergency Departments involved her being conveyed by the London Ambulance Service.

5.20 Agencies working with Amanda also worked at **Step B** of this framework, adopting Multi-Agency approaches.

5.21 The records supplied to this review evidence very many contacts with Amanda and much collaboration and communication between the agencies involved in her care.

5.22 During the review period there were some key meetings to review the circumstances of Amanda's care and support and her use of local services.

5.23 In July 2018 Lewisham and Greenwich NHS Trust drew up a Frequent Attender Anticipatory Management Plan, which was scheduled to be reviewed in January 2019. The document includes content contributed by Amanda.

5.24 In December 2018 mental health services held a Multi-Disciplinary Team planning meeting which Amanda attended. In March 2019 this was followed by a Care Programme Approach (CPA) Review meeting, also attended by Amanda.

5.25 The notes of the MDT planning meeting reference that the meeting was called in response to The Care Home's concerns about the impact on Amanda's physical health of her alcohol use and the risk of fire from careless smoking. The notes of this meeting reference that Amanda is attending A&E on average at least once a week. The CPA meeting notes reference Amanda's continued falls and the need to support her with smoking cessation. However, the notes of the CPA meeting do not evidence an explicit evaluation of the continued risks that Amanda is experiencing. They do contain a series of planned actions that would support Amanda's ongoing engagement with harm minimisation and detox. Neither meeting evaluates the risks associated with Amanda's social network.

5.26 **Safeguarding practice and procedures**

5.27 Amanda's dependence on alcohol caused her much trouble. Without any doubt, she was at risk of physical, sexual, emotional, and financial abuse especially when she was out and about on the streets. These circumstances established a set of rights under the terms of the Care Act 2014 and the associated Care and Support Statutory Guidance.

5.28 The Care and Support Statutory guidance says this about adult safeguarding: *"Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances."*

5.29 Amanda had needs for care and support and these were recognised through her placement at The Care Home. She was at risk and experienced abuse and neglect. Her needs were such that there were circumstances where she was unable to protect herself against neglect and abuse, or the risk of it.

5.30 There is no doubt that Amanda was in need of safeguarding, and those involved with her worked with her in this context. Her care was coordinated by SLaM which included integrated services from the London Borough of Lewisham Adult Social Care. She lived at The Care Home and her placement there was funded to meet the needs she had that related to her mental health problems and reduce the risk of her mental health condition getting worse.

5.31 During the period of this review, Lewisham's Adult Mental Health Safeguarding Team received at least eight separate safeguarding notifications or concerns in relation to Amanda. Some of these came from the police who had recorded incidents on their Merlin[8] database. Others came from health practitioners. The

[8] The Merlin database run by the Metropolitan Police is used to record, action and track safeguarding concerns about children and vulnerable adults. In relation to adults Adult Come to Notice (ACN) reports are submitted to the MERLIN system and are made

Care Home was linked to the NHS Datix[9] database enabling them to report clinical and non-clinical incidents relating to their residents, including Amanda. The Care Home has confirmed that there was a mechanism in place to share this information with Amanda's care coordination team at SLaM. The Datix incidents reported in relation to Amanda did not always convert into reported safeguarding concerns.

5.32 There are occasional references in the records to Amanda making allegations some of which are not followed through, it appears on the basis that they were confabulated accounts.

5.33 The responsibility for follow through on the safeguarding implications of the reported incidents and concerns rested with Amanda's care coordination team at SLaM.

5.34 There is evidence in the chronologies of involvement with Amanda that the risks she experienced outlined in 5.14 above were being discussed both with her and between some of the agencies involved in her care.

5.35 What does not appear to happen is sufficient professional recognition of the ***volume and frequency*** of incidents relating to Amanda's personal safety in the community.

5.36 The records supplied to this review do not evidence detailed follow through on all the recorded incidents or concerns, for example with the initiating of a formal safeguarding enquiry. S42 of the Care Act 2014 sets out the provisions for these enquiries. Lewisham's procedures were clear in this regard, with an established pathway of actions to follow when safeguarding concerns were raised, via the formal safeguarding route. Any other means used to record safeguarding incidents, such as Datix, would require a separate safeguarding concern to be raised formally.

5.37 The convening of safeguarding meetings leading to agreed documented actions which could be monitored for implementation and review are an important step in safeguarding pathways. It may not have been appropriate to convert every concern raised in relation to Amanda into a safeguarding enquiry. However, there is little evidence in the records that the Adult Mental Health Safeguarding Team reviewed each concern formally in accordance with local and national safeguarding policy and practice to determine whether to proceed with a S42 enquiry. Furthermore, the high tide of a range of different incidents of physical harm should have triggered a broader level of safeguarding enquiry into Amanda's safety in the community.

5.38 In April 2021, Lewisham published and disseminated their Adult Safeguarding Pathway[10]. The notes within this website based guidance remind practitioners

whenever Metropolitan Police Service Officers encounter adults who may be considered 'vulnerable' by means of mental health, age, illness, or disability.

[9] The Datix database is used by the NHS to record, action and track patient safety related incidents.

[10] https://www.safeguardinglewisham.org.uk/lsab/lsab/lewisham-adult-safeguarding-pathway/safeguarding-pathway

and organisations of the risks of *Normalisation*: "This refers to social processes through which ideas and actions come to be seen as 'normal' and become taken-for-granted or 'natural' in everyday life. Because they are seen as 'normal' they cease to be questioned and are therefore not recognised as potential risks or assessed as such."

5.39 Although the evidence in the records suggests that the overall approach to Amanda was personalised and attentive to many of her needs, there are questions to be asked about the extent to which practitioners might have become inured and accustomed to dealing with her very excessive drinking at the expense of evaluating the compounded dangers she was experiencing.

5.40 What is certainly missing in the records is professional curiosity and focus on the dangers that Amanda faced while intoxicated out and about, away from her home. She lost possessions in the street and from time to time she would report that she had been robbed. Her injuries were very frequent and some of her injuries and bruising were suggestive of assault. She was regularly found in the street completely intoxicated and unable to protect herself.

5.41 These numerous events did not result in an escalation of safeguarding enquiries and actions.

5.42 Against a backdrop of continued high levels of alcohol use, the picture of risk was stark given the multiple Emergency Department attendances, inpatient admissions, police involvement in community incidents, safeguarding enquiries raised, and The Care Home raising Datix reports, which were reported as incidents to Amanda's care coordination team at SLaM.

5.43 Amanda's multiple and frequent injuries should have provoked a more determined safeguarding assessment and plan. The fact that they didn't, suggests that practitioners may have been lulled into normalising the level of injuries she was sustaining. There were many things that were going well for Amanda, and it is possible that the optimism that services may have felt contributed to practitioners becoming habituated to tolerating levels of injury that they should not have.

5.44 Normalisation and desensitisation to events in a person's life, and the risks the person may be experiencing, are recognised dangers in safeguarding practice. Practitioners may become so accustomed to patterns of behaviours in an individual that they no longer are startled by events that might shock them if they happened to someone else in different circumstances.

5.45 In the aftermath of her disappearance in May 2019 and the discovery of her body, it became clearer that Amanda had been associating with street drinkers and street dwellers. Some of this had been known to some agencies, but the picture had not previously crystallised sufficiently to escalate the risks she experienced from the people she associated with when out and about.

5.46 Amanda's sister had raised questions about the possibility of a different type of placement, as had the escalation on occasion after they had dealt with a

community incident. A detox placement was accepted as an important next step by the agencies working with Amanda. Planning was underway for Amanda to detox from alcohol in a specialist detox and rehab placement.

5.47 One way of acknowledging the risk picture and considering what might be done to mitigate further would have been to convene a full Multi-Agency risk assessment panel attended by all the agencies working with Amanda and any agencies that might contribute to potential mitigations.

5.48 The primary responsibility for this would have rested with the SLaM care coordination team, but a request could have been made to them by any of the agencies working with Amanda.

5.49 The London Multi-Agency Adult Safeguarding Policy and Procedures describe this arrangement as follows

5.50 "*Community Multi-Agency Risk Panels are one type of Multi-Agency working on complex and high-risk cases, often where agencies spend significant amounts of time responding to difficult, chaotic or problematic behaviour or lifestyles that place the person, and possibly others, at significant risk. Panels can be created with all necessary partners, both statutory and third party and will vary depending on local need of the case in question. Any situation calling for Multi-Agency action could be discussed at panel meetings. The panel will support agencies in their work to lower and manage risk for both individuals and the wider community.*

5.51 *Community Multi-Agency Risk Panels are based on the belief that shared decision making is the most effective, transparent and safe way to reach a decision, where there is challenge with the adult at risk and professionals working with them to mitigate the risk; or where there is a highly complex case and the risk needs to be escalated for consideration by such a panel. The purpose of the Panel is to agree a risk reduction plan that is owned and progressed by the most relevant agency with the support of necessary partners."*

5.52 However, within the period of this review Lewisham did not have a simple mechanism for convening such panels.

5.53 More recently, commissioned services in Lewisham have established a Complex Needs Multiagency Panel. However, when the reviewer met with practitioners (see 2.10 above), not all agencies were aware of its existence. Furthermore, it is not linked explicitly to Lewisham's Adult Safeguarding Pathway[11].

5.54 As this panel did not exist at the time of the review, Lewisham's safeguarding adults' procedures could have been used to serve the purpose of Multi-Agency risk assessment and planning. However, as agencies working with Amanda were not making full use of Lewisham's safeguarding adults' procedures on behalf of Amanda this option was not pursued on Amanda's behalf.

[11] https://www.safeguardinglewisham.org.uk/lsab/lsab/lewisham-adult-safeguarding-pathway/safeguarding-pathway

5.55 Had a Multi-Agency risk panel been convened, it might have been able to consider:

- The nature, volume and frequency of the safeguarding incidents and concerns, the multiple Emergency Department visits and the five hospital admissions, incidents involving the police, the incidents reported on Datix by The Care Home. What did this composite picture reveal about the risks that Amanda was experiencing continuously?
- Involving Community Safety colleagues in assessing any risks to Amanda and the wider community from her street associates;
- Progressing and expediting the planning for the detox placement and Amanda 's post-detox care and support arrangements which would also have required a focus on relapse prevention;
- Discussing all of this further directly with Amanda.

5.56 The planning for Amanda's residential detox had begun, but the process of agreeing the arrangements had not been completed. Of course, this placement was contingent on Amanda's collaboration. Engaging with her to expedite Amanda's detox placement and developing a post-detox plan with her, would have been a safety promoting next step. Developing this plan assertively might also have contributed to a useful discussion with Amanda about her longer term personal safety.

5.57 A Multi-Agency risk panel might also have weighed up the options available to them under **Step C** of the framework.

5.58 **Acting in Amanda 's best interests - agency use of legislation, statutory guidance and codes of practice in relation to Amanda 's capacity to make her own decisions**

5.59 As Amanda's schizophrenia was stable and unproblematic during the period of her review, there were no circumstances in which clinicians needed to consider using any of the powers available under the Mental Health Act 1983 (amended 2007). Amanda's placement was funded under s117 of the Act and her care was being coordinated under the provisions of the CPA. She had regular reviews.

5.60 When Amanda was intoxicated, and when she was recovering from a head injury, her capacity to make decisions was seriously compromised. Furthermore, a background history of substance use and head injuries from young adulthood onwards, was likely to mean that her capacity to commit to the actions needed to implement a decision was also compromised. The records evidence that her executive capacity was being considered by agencies working with Amanda, as they engaged with her.

5.61 When Amanda was heavily intoxicated, any intervention that was attempted by others needed to be considered in the context of her best interests. While there are examples in the records of Amanda's Mental Capacity being considered, many of the records are silent about whether her Mental Capacity was assessed on occasions that interventions were made.

5.62 This review has not found any examples of active interventions that would not have been likely to be in her best interests. However, the decision making processes are often not explicitly set out in the records that were provided to the review.

5.63 There were many times that decisions were being made in Amanda's best interests when she was intoxicated, and unable to make those decisions herself. It would have been appropriate to appoint an Independent Mental Capacity Act advocate or an advocate under the provisions of the Care Act 2014 to represent Amanda's views and opinions. As Safeguarding Concerns were raised in relation to Amanda and some of these concerns should have resulted in Safeguarding Enquiries, she could also have been supported by advocacy to support her contribution to the enquiries and the plans for her safeguarding. There is no evidence in the records that this was considered or discussed between professionals or with Amanda. That said, there is evidence in some key meetings of Amanda's personal contribution and her voice in the proceedings.

5.64 The Mental Capacity Act (2005) and its associated Code of Practice and guidance makes provision for people to be subject to Deprivation of Liberty Safeguards (DoLS). Where people cannot consent to their care arrangements in a care home or a hospital, the Local Authority can authorise a DoLS, enabling carers to use restraint and restrictions in the person's best interest. There are detailed procedures that must be followed to assess and to put the deprivation arrangement in place.

5.65 There are several references in the records which indicate that the possibility of assessing Amanda for a DoLS was being considered. Had one been put in place, it could have meant, for example, that staff at The Care Home could have prevented her from leaving the home if they felt that her level of intoxication meant that she could not keep herself safe while out and about.

5.66 Amanda was formally assessed for a DoLS in November 2017 and the doctor who assessed her determined that she did not meet the criteria for her liberty to be deprived in this way.

5.67 On several occasions, the records supplied for this review indicate that Amanda, especially when sober, did have capacity to make decisions. There are some references to Amanda's executive capacity, which is her ability to follow through on decisions. It is clear that those working with her, were often working to maximise her ability to commit to her intentions to reduce her alcohol consumption; even to abstain.

5.68 Amanda's executive function or dysfunction is not explored in detail in the records supplied to the review. In the context of someone with a long history of substance use and misuse, the records are largely silent on how compulsive her use of alcohol must have been, leading to what was effectively self-neglect and real difficulties in following through on her stated intentions. It is likely that the one to one sessions and group work that Amanda was undertaking at CGL would have addressed this with her, especially in preparation for a detox placement.

5.69 When the reviewer met with practitioners who had been involved in Amanda's care and support, or who had contributed to their own agency reviews, the consensus was that implementing a DoLS with Amanda would have not been a feasible option for health or care providers to implement. For example, if Amanda left the care home not yet very intoxicated, it would not have been possible to restrain or detain her. This is despite the probability that sometime later she might be severely intoxicated.

5.70 What is not evident in the records of agencies' involvement with Amanda is a frank assessment of the very significant risks that she faced when out and about and intoxicated - from falls, from road traffic accidents and to her physical and sexual safety. These risks should have been more explicitly evaluated in a Multi-Agency risk assessment process. Not doing so had the potential to exacerbate the risks and place the care home in a position where they managed a risk not fully recognised nor potentially mitigated by the Multi-Agency system of health, care and support.

5.71 The care home was in the invidious position of knowing that despite not being able to detain Amanda when sober, if she left the home sober to buy and drink alcohol, she would be in significant danger of falls or violence later.

5.72 Possible outcomes from a Multi-Agency risk assessment could have included further mitigating actions such as:

- A legal and expert practitioner review of the circumstances of Amanda 's fluctuating capacity to determine whether there were options available to practitioners to detain her under either the Deprivation of Liberty Safeguards or through an application to the Court of Protection
- Expediting Amanda 's detox placement and forward planning for her post-detox care, support and accommodation needs
- The use of personal protection devices and assistive technology could have been considered in discussion with Amanda to determine her willingness to use such harm minimisation approaches such as head and hip protection, or any functionality on a smart phone that could support finding her if she collapsed away from her home.

6. Agency Oversight and Quality Assurance Arrangements

6.1 The Terms of Reference for this review invited the participating agencies to reflect and comment on the ways in which their agencies supported their safeguarding practice.

6.2 The responses evidence a wide range of measures including supervision, consultation on complex cases, and training. Some agencies have taken the opportunity to review and enhance some of these arrangements, focusing on some of the themes that they identified in their Individual Management Reviews.

6.3 The circumstances of the boarding up of the garage where Amanda's body was eventually found were reviewed by Lewisham Homes senior management and a

local elected member. That has led to a change of policy and procedure which now requires that abandoned garages are cleared and/or high value items are stored, and an inventory kept, before such garages are boarded up.

6.4 Amanda's placement at The Care Home was commissioned. Her progress in the placement was reviewed through her care coordination arrangements, and her family were pleased with her experience there. The home was registered and inspected by the CQC, as well as being monitored by the Joint Commissioners.

6.5 Multi-Agency or multi-disciplinary reviews of Amanda's care were convened, often involving her directly. These meetings resulted in plans of action that were followed through.

6.6 What was missing in Lewisham at the time that this review covers is a simple and widely known mechanism to convene a whole system risk assessment meeting (as described from 5.50 above).

7. Conclusion

7.1 Amanda's lifetime use of substances, and alcohol in particular, as well as her underlying mental illness, created many risks to her wellbeing and to her life itself.

7.2 The many agencies working with Amanda during 2018 and 2019 addressed many of these risks with her and in their planning for her.

7.3 Agencies worked together in Amanda's interests and worked with her to develop implementable approaches to engage her in self-determination and self-protection. During this period Amanda's mental ill health was stable, she successfully completed treatment for her Hepatitis C, she remained in her residential placement, and she was making efforts to reduce her alcohol intake in anticipation of a new opportunity to detox. Her GP practice was monitoring her health status actively with her and in communication with her professional network. Amanda maintained some social contact with her family.

7.4 However, as well as these successes, Amanda had numerous falls and injuries, some of which may have been caused by assault. She had multiple attendances at Emergency Departments, conveyed there by the police and the LAS. Her physical health, though improving in some areas, was presenting other challenges, such as reduced mobility. It is this picture that was not fully addressed by the agencies working with Amanda.

7.5 The chronologies provided to this review indicate that the NHS Datix database was used by The Care Home to report safety incidents involving Amanda. This is not the appropriate mechanism for raising safeguarding concerns.

7.6 Furthermore, there is no evidence in the reports provided to this review that the Adult Mental Health Safeguarding Team were receiving or collating the Datix report information relating to Amanda systematically and considering the safeguarding implications. There were a number of occasions when this should

have resulted in a Safeguarding Enquiry. The Adult Mental Health Safeguarding Team should also have taken action to ensure that The Care Home raised Safeguarding Concerns as well as Datix entries.

7.7 When the Adult Mental Health Safeguarding Team was receiving Safeguarding Concerns through other routes, there is little evidence that they were progressing any of these concerns to a full S42 Safeguarding Enquiry. There is some evidence in the records that there was an expectation that safeguarding issues would be addressed through the CPA review process. The notes of the CPA review meeting which took place in March 2019 have very little explicit safeguarding focus.

7.8 As well as agencies frequently not responding to single incidents within the local safeguarding protocols, the evidence in this review suggests that the network of agencies involved in caring for Amanda were, at least to some extent, so accustomed to the volume and frequency of injury that Amanda was experiencing, that they did not step back together, as a whole system, to assess together whether there were further mitigations that might have been put in place.

7.9 If the provisions of s42 of the Care Act 2014 had been used appropriately, a Safeguarding Adults Manager would have been appointed to oversee Amanda's case and ensure that a whole system review was undertaken. This needed to have happened in Amanda's best interests.

7.10 There was also a wider system issue for Lewisham to have considered in relation to the opportunity costs arising from Amanda's very high use of health, care and police resources. Finding a way of supporting Amanda differently, might have released resources to address other community needs.

7.11 The practice dilemma for all those working with Amanda was whether there were lawful ways of limiting her access to alcohol. It was when she was intoxicated, that she was most at risk of falls and assaults from others. Practitioners and agencies were working with her actively to help her reduce her alcohol intake and Amanda was successful some of the time. However, when the compulsion to buy and consume alcohol was strong, Amanda was likely to consume heavily.

7.12 A legal and expert practitioner review of the circumstances of Amanda's fluctuating capacity should have been commissioned to determine whether there were options available to practitioners to detain her under either the Deprivation of Liberty Safeguards or through an application to the Court of Protection.

7.13 Expediting and progressing the planning for the detox placement was a strategy which could have been pursued in parallel, including planning for Amanda's post-detox care and support arrangements which would also have required a focus on relapse prevention.

7.14 The discovery of her body hidden in a boarded up garage suggests that in her final moments of life she was also not protected by those she was with.

7.15 If this outcome could have been avoided, then local agencies would have needed to have attempted to develop a better understanding of whether Amanda could have been protected differently from her own actions and from the actions of others.

7.16 This Safeguarding Adults Review cannot say with 20/20 hindsight say what a Multi-Agency risk panel might have determined, but it can suggest that as a minimum a panel needed to have been convened to consider alternatives to the status quo of Amanda's care and support arrangements.

7.17 The agencies involved in the Safeguarding Adults Review were approached formally in October 2021. This was a time when many services were continuing to adjust to the significant ongoing workforce and operational challenges of the Covid-19 pandemic. Against this background context, the review was slow to get underway. Some of the agencies who were involved in the care and support of Amanda delayed in submitting their written responses and the reviewer was not able to begin the review until these were complete.

7.18 It is of note and concern that a very short document from the Care Quality Commission took them six months to submit. This was despite many prompts and reminders.

8. Recommendations

8.1 Lewisham Safeguarding Adults Board: As a matter of urgency, co-ordinate a review of the use of Datix as the sole means of care home providers reporting safeguarding incidents.

8.2 Lewisham Safeguarding Adults Board: Seek assurances that there is system-wide agreement about Datix data flows to enable appropriate governance oversight of Datix incidents with safeguarding implications.

8.3 The Adult Mental Health Safeguarding Team: Review their compliance with the Lewisham Adult Safeguarding Pathway. This should include the provision of advocacy support.

8.4 Lewisham Safeguarding Adults Board: Establish clearer pathways and protocols for convening community Multi-Agency risk panels.

8.5 Lewisham Safeguarding Adults Board: Refresh local guidance about agency responses to requests for information for Safeguarding Adults Reviews.

8.6 Care Quality Commission: Review the circumstances that led to the six month delay in supplying information to this SAR and take action accordingly.

8.7 Metropolitan Police Lewisham and Safer Lewisham Partnership to maximise the safety of vulnerable residents who mix with Lewisham's street population.

8.8 Lewisham Safeguarding Adults Board: Convene local training on *How to use legal powers to safeguard highly vulnerable dependent drinkers in England and*

Wales. (Alcohol Change UK). The training should reference this SAR and the issues it raises, including normalisation and desensitisation, but also draw on wider case examples. Disseminate practice guidance.

8.9 Lewisham Safeguarding Adults Board: In the light of the planning for recommendation 8.8, consider the wider need for a local training offer that addresses how agencies address working with the dynamics of normalisation and desensitisation.

8.10 Metropolitan Police Lewisham: In consultation with Amanda's family, review the approach they took to investigating Amanda's disappearance when it was reported on 15 May 2019.

8.11 Lewisham Safeguarding Adults Board: Remind all local agencies of the importance of recording mental capacity assessments/best interest decisions on all occasions.

8.12 Lewisham Safeguarding Adults Board and Safer Lewisham Partnership: Remind all agencies of the requirements to follow Domestic Abuse protocols when interviewing individuals who have sustained personal injuries.

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