Hertfordshire
Safeguarding Adults Board

SAFEGUARDING ADULT REVIEW
“Alex”

2023

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Patrick Hopkinson

SAFEGUARDING ADULT REVIEW

Hertfordshire Safeguarding Adults Board

1. INTRODUCTION

1.1. Alex was a 50-year-old white British man who had a long history of contact with services. He had a significant history of alcohol and physical health problems, associated with sustained alcohol use and falls when intoxicated. Alex also had a history of malnutrition, eating difficulties and clinical depression.

1.2. On the evening of 2nd March 2022, Alex died in a fire at his property. The Fire Service investigation concluded that it was an accidental smoking related death.

1.3. Safeguarding concerns had been raised about Alex to Dacorum Adult Community Mental Health Services (ACMHS) on 8th January 2021 and 14th May 2021, due to the presentation of his home, his ability to care for himself and concerns that he was being cuckooed.

1.4. A plan had been put in place but a lengthy hospital admission had complicated its implementation. Latterly Alex had declined support from CGL, adult safeguarding and a deep clean of his property but he was agreeable to moving to alternative accommodation.

1.5. Both safeguarding referrals remained open, and work continued with Alex around his safeguarding, until his death.

1.6. It appears there was no proactive follow-up from mental health services during the two weeks directly following Alex's discharge from Watford General Hospital (WGH) on the 3rd November 2021. Alex contacted the Single Point of Access (SPA) helpline on 13th November 2021 and the Crisis Recovery Home Treatment Team (CRHTT) telephoned him on 14th November 2021. It appears there was no contact by services with Alex for eight weeks between December and February 2022.

1.7. Alex originally had accepted a referral for a deep clean but later in the process he declined. No reasons for Alex's refusal of this offer were recorded.

2. SAFEGUARDING ADULT REVIEWS

2.1. Section 44 of the Care Act 2014 places a statutory requirement on the Hertfordshire Safeguarding Adults Board to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Hertfordshire 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.

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

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

2.4. This case was referred to the SAR Sub-group of the Hertfordshire Safeguarding Adults Board on 19th April 2022 and was considered by the Sub-group on 14th June 2022 and on 14th July 2022 when the decision to go ahead with a Safeguarding Adult Review was made.

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

2.6. Alex's death was considered under NHS England's Serious Incident Framework https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf and an Initial Incident Review (characteristically termed the 72-hour review) was conducted. Some information from this review was made available to the SAR author.

2.7. **The review**

This safeguarding adults review commenced on 8th February 2023.

2.9 Key areas to be addressed by the review were:

- How well were risks recognised, assessed and mitigated/ managed?
- Was the interrelation between, and increased risk presented by, alcohol and smoking recognised, assessed and mitigated/ managed?
- To what extent were appropriate harm reduction interventions attempted (fire safety, vaping, "safer drinking")
- What was the understanding of Alex's mental capacity to, for example, make and implement decisions to keep himself safe and was the impact of head injuries, Vitamin B1 depletion, malnutrition on cognitive process (and particularly frontal lobe problems) recognised?
- To what extent was Alex's self-neglect recognised and understood in the context of alcohol use?
- How effective was multi-agency working and information sharing? Were appropriate partners engaged?
- Were any high-risk or self-neglect protocols and forums used and how effective were they?
- How effective were hospital discharge and safeguarding processes?
- How was the concern that Alex was being cuckooed responded to?
- How were Alex's family involved and what could have been done to support them?
- How effective was communication between agencies?
- What impact did Covid have on individuals and the system and their responses to Alex?

2.10 **Contact with family and friends**

2.11 The SAR author tried to contact Alex's father during the process of the SAR. The SAR author was telephoned by Alex's sister who said that Alex's father had sadly passed away. Alex's father, had however, previously contacted HPFT and his views were incorporated in its IMR and fed into the SAR panel discussions. In this way, the SAR is informed indirectly by the views of Alex's father.

2.12 The SAR author also spoke with Alex's sister who contributed essential information and fact checking and confirmed her satisfaction with the report.

2.13 **Agencies involved in the review**

2.14 The following services were involved with Alex during the time covered by the chronology:

- Hertfordshire Partnership University NHS Foundation Trust (HPFT)
- West Herts Hospital Trust
- Hertfordshire Community NHS Trust
- ACMHT (Dacorum Adult Community Mental Health Team)
- SPA (Single Point of Access)
- Buckinghamshire Healthcare NHS Trust (Stoke Mandeville Hospital)
- Dacorum Borough Council
- Change Grow Live (CGL) (Drugs and Alcohol Service)
- Hertfordshire County Council (HCC) – Adult Care Services (ACS)

- Hertfordshire Police
- Hertfordshire Fire and Rescue Service
- East of England Ambulance Service
- GP – Gossoms End Surgery

3. BACKGROUND and BRIEF SUMMARY OF CHRONOLOGY AND CONCERNS

3.1. The information supplied for this safeguarding adults review covered the period from 27th December 2019 to 2nd March 2022. During this time, there were almost 400 entries made by the various agencies who had contact with Alex. The following chronology provides a brief summary of events.

3.2. **Alex - Background**

3.3. Alex was a white British man who was 50 years old when he died in a fire.

3.4. According to HPFT, Alex was diagnosed with mental and behavioural disorders due to use of alcohol (dependence syndrome). Alex's sister felt that he had developed mental health needs first, after which he began to drink heavily, possibly as a means of self-medication. Alex's sister also believed that Alex was embarrassed by his mental health difficulties and that feelings of guilt and shame led him to refuse support. Alex also did not like being in a group of people and would not accept help from his family.

3.5. Alex had poor physical health with an oesophageal tear, which became a stricture, and mobility difficulties. Alex also smoked cigarettes. Alex had a documented history of struggling with issues relating to low self-esteem and self-worth, depression and low motivation since his teenage years. Alex also reported hallucinations and hearing voices and it is therefore possible he had a form of psychosis, however this was never diagnosed. Alex was adopted as a child. According to Alex's sister, Alex was unaffected by this but, despite being loved by his family, lacked self-esteem. Alex's adoptive family were very academically capable whilst Alex had considerable practical and especially mechanical skills. Alex said that he had enjoyed school and was popular but described himself as shy. Following school, Alex had worked in a garage for eight years, however after the company ceased trading Alex struggled from the age of 24 years old to maintain steady employment. Alex had most recently worked as a hospital porter.

3.6. During the practitioners' session for this review, it was reflected that the ending of a relationship with a partner may have triggered Alex's substance misuse. Alex sister, however, said that Alex not been in a relationship for 15 years. Alex lived alone but received practical and financial support from his mother until she developed dementia and then his father. Alex's father continued supporting him whilst caring for Alex's mother. Alex's mother's dementia was described as a source of sadness for Alex. Alex said his mother may not have recognised him due to her condition. Alex had refused to have a Covid-19 vaccination and so could not visit his mother who was being shielded. Alex had established some connections with his neighbours, but appeared to be generally reclusive in nature.

3.7. Alex's home comprised of a two storey accommodation with a bedroom upstairs, but during the time of the review he was living and sleeping downstairs due to mobility issues.

3.8. Alex had sustained a hip fracture in May 2019, the cause of which is not recorded, and found it difficult to mobilise, take care of himself and keep his home clean and tidy. Alex's sister believes that Alex may have refused physiotherapy. There are numerous references to difficulties eating due to issues with his oesophagus and concerns regarding his low weight.

3.9. **Summary Chronology**

3.10. On 20th January 2020, Alex was admitted to Stoke Mandeville Hospital with pneumonia and remained there until 17th February 2020.

3.11. There was a concern that Alex might have lung cancer and on 26th February 2020 a referral was made to Harefield Hospital for further investigation. No malignancy was found and Alex was believed to have a pulmonary abscess, possibly due to an oesophageal stricture, excess alcohol intake and not eating soft food.

3.12. On 25th March 2020, during a follow up telephone call from Stoke Mandeville Hospital, Alex said that he was struggling to eat food, but that this was improving. Two weeks before, Alex had started to drink a bottle of vodka each day but reported that he had stopped this now.

3.13. In the evening of 12th April 2020, EEAS took Alex to WGH (Watford General Hospital). Alex had run out of medication, felt depressed and wanted to hang himself if left at home. Alex showed some indicators of self-neglect (urinating, and putting out cigarettes, in a bowl by his bed, having little food, but lots of vodka bottles in the house). Alex was not in current contact with mental health services. Alex was assessed in hospital, where alcohol use was identified as the primary treatment need. Consequently, Alex was signposted to CGL and agreed to self-refer. Alex's father was updated on events.

3.14. On 21st May 2020, Alex's sister telephoned for an ambulance since Alex had told her that he had been advised by a paramedic that he had had a "mini stroke", and his speech sounded slurred. Alex had lost his sense of smell and taste and had been told by 111 that he was highly likely to have Covid-19 and was advised to isolate. Alex gave permission for the ambulance crew to refer him for support with alcohol addiction and for a medication review.

3.15. On 2nd July 2020, Alex called for an ambulance since he had abdominal pain and difficulty breathing. Alex's history of substance dependency was noted and he disclosed that he was struggling to cope with his mental health and there was a lack of support services during Covid. Alex refused to allow the ambulance crew to make a referral to his GP. A mental health street triage car was requested.

3.16. On 3rd July 2020, the mental health street triage team referred Alex to CGL and notified Alex's father of the concerns about Alex experiencing physical health problems as a result of alcohol withdrawal.

3.17. On 10th July 2020, Alex was taken by ambulance to Watford General Hospital with chest pain and shortness of breath.

3.18. Between 20th July and 19th August 2020, CGL completed its triage and assessment process with Alex.

3.19. On 23rd August 2020 was taken to WGH by ambulance. An ambulance with flu-like symptoms (understood to be Covid-19) and with right chest pain and hallucinations after taking cocaine and heroin. Alex said that he felt his mental health was deteriorating and his drug use (which had started during the Coronavirus pandemic) and alcohol use had increased, he was struggling to cope and felt hopeless. The ambulance crew noted that Alex appeared to be wasting away with reduced food and fluid intake, was unkempt and the house was untidy. Alex was taken to WGH.

3.20. Between 1st September 2020 and 29th September 2020, CGL managed to speak to Alex once, but all other attempts to contact him were unsuccessful.

3.21. On 4th October 2020, Alex was taken by ambulance to Stoke Mandeville Hospital with breathing problems. The crew noted that Alex was using a bucket by the side of his bed as a toilet, was unable to stand and was not eating.

3.22. On 7th October 2020, Alex contacted CGL, who on 8th October sent him diaries for recording his alcohol intake.

3.23. On 30th October 2020, Alex was taken to WGH by EEAS confused, disorientated and expressing suicidal thoughts. He was described as appearing frail, emaciated and responding to hallucinations. Alex was admitted as an in-patient having been assessed by the Mental health Liaison Team (MHLT). The following day, an error was made on the ward which led to Alex being discharged as medically fit without being further assessed by the MHLT.

3.24. Shortly after Alex's return home he was reported to have started drinking again resulting on 3rd November 2020 in admission to Stoke Mandeville Hospital due to overdose, suicidal ideation and self-harm.

3.25. Between 13th April and 11th November 2020 there were seven contacts between Alex and the HPFT spread between MHLT in WGH, the Crisis Recovery Home Treatment Team (CRHTT) and the Street Triage team. These were contacts largely instigated by Alex after presenting in accident and emergency with physical health issues and suicidal ideation.

3.26. On 9th December 2020 a referral was received by the Early Intervention Service from the Complex Needs Service. This identified that Alex had physical health issues as his hip had not healed as it should, that he was sleeping downstairs, had poor mobility, was struggling to eat and consequently he was under-weight. This referral was passed

to the Targeted Intervention Service, who made a referral to the Herts Care Line for a pendant alarm.

3.27. Before the case was allocated, a further adult social care referral was received from EEAS on 8th January 2021. On 7th January 2021 EEAS were called out to Alex. He had a temperature, was confused and suicidal. EEAS reported that Alex was under-weight, covered in faeces and urine and had mental health needs. Alex's home was cold with no food in the house. EEAS took Alex to WGH, where he was admitted under a "social needs" admission.

3.28. On 8th January 2021 WGH made a referral for an assessment of Alex's needs as part of the discharge planning process and raised a safeguarding concern to ACMHS regarding suspected cuckooing at Alex's home address. This had been disclosed by Alex while in hospital. There was some initial joint working between the MHLT and CGL, who agreed to discuss collaboratively their concerns with Alex during his hospital stay. Alex was discharged on 12th January 2021.

3.29. On 24th January 2021 Alex was taken to WGH after consuming 500ml of vodka and tying a belt around his neck, which he said demons had told him to do.

3.30. On 1st April 2021 EEAS took Alex to WGH as he was expressing suicidal ideation. The Mental Health Street Triage Team were unavailable to assess Alex. EEAS took Alex to WGH.

3.31. On 18th April 2021 Hertfordshire Urgent Care line called the police as Alex had tried to hang himself. EEAS were called and Alex refused to be taken to hospital. EEAS assessed Alex to have the mental capacity to make this decision.

3.32. On 13th May 2021 a safeguarding referral was received from Dacorum Borough Council (DBC) stating that the police had been called and visited the property. Alex had told them that he was being cuckooed and that his property was being used for dealing and processing drugs. The referral detailed the state of the property, and that Alex was struggling with his mobility. This referral was passed on to the SPA at HPFT. It was not possible to determine whether Alex was unable to protect himself from the self-neglect, so an "other safeguarding enquiry" ensued. This type of enquiry is not a statutory enquiry. However, it can be used when it has not been possible to satisfy all three parts of the test for a s42 enquiry and preventative action is required. A home visit took place on 19th May 2021 with information gathered on Alex's needs and assessed risk. An initial strategy discussion took place on 19th May 2021. It appears that DBC was not included in this meeting, however a plan was made which required input from DBC, the Social Prescribing Service, CGL and Alex's GP. Apparently unaware of the strategy meeting DBC visited Alex's property on 21st May, 28th May and 4th June 2021 prompted by the cuckooing concern and a report of possible rat infestation.

3.33. On 1st June 2021 a safeguarding referral was sent by Buckinghamshire Healthcare NHS Trust to ACS after Alex had called an ambulance and had been taken to Stoke Mandeville Hospital. The referral detailed Alex's alcohol misuse and concerns regarding his mobility and low weight. This was passed to SPA at HPFT.

3.34. On 10th June 2021 Alex telephoned DBC to explain that he was out of hospital, that he was depressed and lonely and that he wanted help with cleaning. DBC discussed current living arrangements with Alex, but he did not want to move. DBC notified HPFT of this.

3.35. On 12th June 2021 the ACMHS converted the non-statutory enquiry (from 14th May 2021) into a s42 enquiry because it was believed Alex was unable to protect himself due to the impact of his alcohol use. A case conference meeting was held on 14th July 2021. It appears that DBC was not invited to this meeting. Actions arising from the meeting were that an update was to be requested from the police about suspected cuckooing, and alternative housing arrangements and a deep clean of the property were to be discussed directly with Alex.

3.36. On 14th July 2021 the Out of County Hospital team sent a referral for an assessment for Alex. Alex had been admitted to Stoke Mandeville Hospital following a fall where he broke his arm. The ward advised that Alex needed support with washing, dressing and preparing food. Support was put in place for Alex's discharge from hospital on 17th July 2021. A food parcel was also arranged.

3.37. In July 2021 (exact date not known) Alex contacted DBC with concerns about managing his finances. DBC adjusted his council tax instalments and discussed his housing options again due to his decreasing mobility. Alex agreed for a referral to be made to the Complex Needs Service.

3.38. A second case conference took place on 29th July 2021 where the police updated the enquiry that the locks on Alex's door had been changed and there had not been any further reports of cuckooing at the address.

3.39. From 30th July 2021 until 14th October 2021 Alex was admitted to the Intensive Care Unit (ICU) of WGH due to an oesophageal stricture. During this time CGL closed Alex's case because of the length of the hospital stay and he was abstinent. Alex was discharged without a support package as Alex refused one.

3.40. On 22nd October 2021 EEAS took Alex to WGH with chest pain and he was admitted again. He was again discharged without a support package.

3.41. On 13th November 2021 EEAS took Alex to WGH as he was suicidal. EEAS made a referral to HCC for a social care assessment. This identified that Alex needed some aids and adaptations such as grab rails and walking aids.

3.42. On 14th November 2021 CRHTT assessed Alex and contacted the ACMHS via email with a proposed plan of support for him. ACMHS missed this email which delayed support being put in place.

3.43. On 15th November 2021 a deep clean of Alex's house was agreed.

3.44. On the 3rd of February 2022, Alex was taken to the emergency department of WGH by ambulance following an overdose of mirtazapine, which he said was intentional. Alex was noted as having reduced significantly in weight with concerns raised around how

he was eating and drinking at home. Alex was noted as having poor dental hygiene. Alex was seen by the MHLT who did not feel acute mental health input was required. They reported they would inform Alex's local mental health team. The following day Alex told the discharge co-ordinator that he was able to clean, shop, and cook, and that his family would collect him when discharged. Alex declined any input from the social work team.

3.45. On 4th February 2022 Alex was transported home by Red Cross patient transport services. The MHLT carried out an assessment and subsequently the ACMHS contacted DBC Housing Department and the See and Solve team at HCC on 9th February 2022 for a deep clean of Alex's property. Subsequently Alex decided he did not want a deep clean and it did not go ahead.

3.46. On 8th February 2022 the ACMHS completed a home visit as part of the ongoing safeguarding enquiry initiated the previous year in May 2021. They observed Alex's mobility was poor and he struggled to use stairs safely. Alex said he wanted to move to a ground floor flat due to his history of falls. He explained he was not at risk of abuse or neglect by others. Alex added he was buying food and this was stored in the fridge and cupboards. The house was reported to be "untidy" Alex declined referrals to CGL and for a deep clean, but agreed to a referral for help with his physical health needs. Alex said he wanted to move into a ground floor flat and for the safeguarding enquiry to be closed. The ACMHS made a referral to HCC Adult Care Services regarding an assessment of Alex's care and support needs and made an occupational therapy referral to ACS. It was agreed that an occupational therapy functional assessment would be carried out.

3.47. On 24th February, following a referral from ACMHS, the Community Safety Action Group (CSAG) discussed Alex's case. DBC advised that it would support Alex to move to a ground floor flat.

3.48. On 27th February 2022 Alex was taken by ambulance to WGH with pain in his arms. Alex declined any input from the social work team and he was discharged the following day. This was the last recorded contact with Alex by any of the services involved with him.

3.49. On 2nd March 2022, Alex died in a fire. The Hertfordshire Fire and Rescue Service Critical Incident Key Information Report completed after Alex's death, identified that the seat of the fire in which Alex had died had been his bed and found evidence of, "remains of cigarette butts, lighters, matches and a matchbox. The electric bed was not plugged in. Other possible alternative sources were identified and ruled out". The fire was determined to have been caused accidentally by the "careless use of smoking materials by the occupant".

3.50. There was a smoke detector without a battery in the ground floor hallway. The smoke detector from the first-floor landing was in a bowl in the bathroom but was not working. A next door neighbour, who tried to enter the property to rescue the Alex, said that no smoke detectors were operating and that, although there was lots of smoke, he could see the whole of the bed alight.

4. THE EVIDENCE BASE FOR THIS SAFEGUARDING ADULTS REVIEW

4.1 The analysis of Safeguarding Adults Reviews by Michael Preston-Shoot (2017) and The Local Government Association Analysis of Safeguarding Adults Reviews April 2017 – March 2019 section 3.4 "*Type of Reviews*" describes a number of "methodological" requirements and related shortcomings of SARs, which can be summarised as follows:

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

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

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

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

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

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

4.8 Several SARs by Patrick Hopkinson (for example, Andrew, Staffordshire and Stoke, 2022; Donna, East Sussex 2023) have identified eleven themes involving self-neglect that are common to all reviews. These themes were based on the initial work by Alcohol Change UK ("Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017", published in 2019) but are present even when alcohol or substance use is not a factor.

4.9 Even when a theme is not present, this assists in building a predictive model that might be used to identify patterns in individuals which suggest that they are at risk of being a future subject of a safeguarding adults review.

4.10 The extent to which they were present in Alex's life is analysed at Section 5.83 of this report.

4.11 **The Blue Light Project**

4.12 Alcohol Concern's Blue Light Project, working with change resistant drinkers, The Project Manual, developed by Mike Ward and Mark Holmes, 2014, provides guidance

on the development of alternative approaches and care pathways for drinkers who are not in contact with treatment services, but have complex needs. Practitioners are guided on managing such individuals through motivational and harm reduction interventions built around assertive outreach and multi-agency working.

4.13 **Dependent drinkers and applying legal powers**

4.14 Alcohol Change UK's guidance on How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales produced by Professor Michael Preston-Shoot and Mike Ward, August 2021, describes common myths or misconceptions identified by professionals about the use of legal powers with dependent drinkers that impede their care. These are shown at Appendix 11.

4.15 This guidance document was available for only the last seven months of Alex's life, but as the purpose of this SAR is for services to learn and develop, the contents of the guidance are relevant and are included in recommendations.

4.16 In addition, legal powers already existed which might have been used to facilitate interventions to support Alex. These included the Mental Health Act 1983; the Mental Capacity Act 2005 and environment health legislation (s287 Public Health Act 1936).

4.17 **Self-neglect practice guidance**

4.18 Alex was recognised to be self-neglecting. He was using drugs and alcohol which were likely have influenced his physical ability to self-care, and there were concerns about fire risk and the cleanliness of his home.

4.19 There is extensive research into, and guidance on, working with people who self-neglect largely but not exclusively produced by Suzy Braye, Michael Preston-Shoot and David Orr. How agencies worked with Alex will be considered in the context of this practice guidance. A summary of the guidance is shown at Appendix 2.

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

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

4.22 This SAR recognises the challenges of practicing in a way which balances the principles of the freedom of choice and self-determination with duties, public expectations and moral imperatives of public services. Alex's sister also recognised the difficulties of balancing personal liberty with personal safety and that Alex was reluctant to receive help. Further information on this is shown at Appendix 3 and the Human Rights Act at Appendix 4.

5. ANALYSIS

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

5.2 **Fire risk**

- *Was the interrelation between, and increased risk presented by, alcohol and smoking recognised, assessed and mitigated/ managed?*
- *To what extent were appropriate harm reduction interventions attempted (fire safety, vaping, "safer drinking")*
- *How well were risks recognised, assessed and mitigated/ managed?*

5.3 Alex died in a smoking related fire at his home. Alex was a dependent drinker of alcohol. He had a bed in his living room where he lived and slept because he had mobility difficulties resulting from a hip fracture and could not get up the stairs. All of these factors increased the risk of a fatal fire.

5.4 There is a strong link between smoking and dependent drinking. In 2012 the Office for National Statistics reported that 70% to 80% of dependant drinkers smoked (Office for National Statistics – Drinking Habits among Adults 2012). There is also a link between dependent drinking and fire. For example, 50% of domestic fires in England are alcohol related fire deaths :: www.forensicmed.co.uk.

5.5 There is a higher risk of fire in accommodation where people smoke. There is an even higher risk when a person who smokes is also a dependent drinker. This is because intoxication may mean they are less careful or they may fall asleep from intoxication while a cigarette is lit. Some dependent drinkers have peripheral neuropathy (caused by alcohol induced Vitamin B deficiency) which can mean they are more prone to dropping items, such as a lit cigarette. It is not known if Alex had peripheral neuropathy but it is a factor for professionals to consider when assessing fire risk.

5.6 Alex, however, did have impaired mobility sufficient to restrict his movement around his home. A disability may hinder a person's ability to escape in the event of fire, as may clutter.

5.7 Clutter and hoarding increases the risk of fire occurring and makes it more difficult for people living in the property to evacuate safely. Fire can spread to neighbouring properties if the level of hoarding is severe or if flammable items such as gas containers are being stored. It can also pose a high risk to fire fighters when attending the scene, hampering firefighting and rescuing operations. National Fire Chiefs Council https://www.ukfrs.com/guidance/search/clutter-and-hoarding

5.8 To help agencies obtain an accurate sense of the level of clutter in a person's home a Clutter Image Rating Scale has been developed, with 1 indicating uncluttered and 9 indicating highly cluttered. Clutter image ratings 1-3 constitute Level 1 where the household is considered standard and no specialist assistance is required. Clutter image ratings 4-6 constitute level 2 where the household environment requires specialist assistance to resolve the clutter. Clutter image ratings 7-9 constitute level 3

where the household environment requires collaborate intervention at a multi-agency level.

5.9 The EEAS took clutter rating scales on three occasions when they were called out to Alex. On 4th October 2020 the clutter rating scale was 4-6. EEAS made a mental health referral via Alex's GP. This did not lead to any action on fire risk.

5.10 On 7th January 2021 EEAS recorded the clutter rating scale as 7. EEAS raised a safeguarding concern the primary focus of which appeared to be about cuckooing. It was noted that Alex's drinking had increased in response to the alleged cuckooing, and that he was smoking. The section 42 enquiry following this, however, did not consider self-neglect, nor the clutter rating scales given by the ambulance service. It is not clear from the records why these were not considered. During the section 42 enquiry there is no record of any fire safety or smoking cessation advice being provided to Alex about consuming alcohol and smoking cigarettes and the circumstances in which a fire might start in his home.

5.11 On 13th November 2021 EEAS recorded the clutter rating scale as 4-6 and on this occasion the ambulance service noted that there was a pile of rubbish by Alex's bedside where Alex smoked, causing a fire risk. EEAS raised another safeguarding concern, however this did not result in any consideration of fire risk.

5.12 HPFT's practice is that clutter image rating scales received on referral forms are captured in subsequent HPFT case notes, and it is rare after this for staff to look back at the original referral forms. HPFT has identified that in Alex's case, the clutter image rating scale was not transferred into or captured in case notes. Therefore it was highly unlikely that clutter image rating scales were known and used in future assessments with Alex.

5.13 In some areas of the UK a clutter rating scale of 5 might trigger a referral for a "safe and well visit" by the local Fire and Rescue Service. A clutter rating scale of 7 should trigger a multi-agency response. However, the clutter ratings for Alex were never passed on to HFRS.

5.14 Professionals, relatives, friends and carers may ask Hertfordshire Fire and Rescue Service (HFRS) to make a "safe and well" visit to someone's home. Alex sister explained that she was unaware of this that considered that the availability **of "safe and well visits" should be promoted more widely.** A "safe and well visit" will check on fire risk and give advice about fire prevention and harm reduction measures. During the years and months leading up to the fire at no point was a request made for a "safe and well" visit for Alex. The first time the fire brigade had contact with Alex was their attendance at the scene of the fire on the day he died.

5.15 On 5th November 2020 the CRHTT completed an assessment which recognised several risks around Alex's self-neglect, but the risks from fire were not considered, nor was advice given or referrals made to mitigate this risk. There appears to have been a discussion with Alex about "safer drinking" at one point, although it is unclear whether this was in the context of fire risk or health risk.

5.16 It appears that the reports and referrals made about Alex to other agencies, such as HCC, did not generally mention his smoking. The main focus was on alcohol, mental health and support needs. The agencies in contact with Alex who knew that he smoked did not appear to be aware of or to have recognised the interrelationship between, and the increased risks, presented by alcohol and smoking. Consequently, opportunities were missed to help improve fire safety measures in Alex's home.

5.17 In the process of this review, HFRS identified that fire safety measures such as stable ashtrays, fire retardant bedding and clothing and even portable misting systems are available. These were not used and it seems that some practitioners were not familiar with them. Not all fire safety measures, however, would have been effective for Alex. HFRS identified that, for example, the presence of combustible materials such as paper and card on Alex's bed, however, would increase the fire risk irrespective of any fire-resistant bedding materials.

5.18 Expecting a someone who is substance dependent to stop smoking in the early stages of treatment for substance misuse may be unrealistic. A "fire safer" standard for cigarettes was introduced in 2011. "Fire safer" cigarettes reduce the risk of a lit cigarette causing a fire when left unattended as they are designed to self-extinguish when not actively smoked. Whilst these may reduce the risk of fire, they do not remove it.

5.19 Vaping is considered a safer alternative to smoking. The National Fire Chiefs Council https://www.nationalfirechiefs.org.uk/Vaping-tobacco-position-statement actively encourage all Fire and Rescue Services to support vaping as a safer alternative to smoking where people are unable or unwilling to quit nicotine use. This is especially the case for people at highest risk from fire, including those who are immobile, who smoke in bed and risk dropping lit cigarettes onto their bedding and clothing. The opportunity to offer a switch to vaping, as well as reducing the fire risk, may also be an opportunity to address health problems and increase engagement and motivation (Mike Ward, unpublished).

5.20 As part of this Review some practitioners across the agencies have suggested the need to include questions about fire risk in forms and assessments that they complete. The London Fire Brigade has a checklist for a Person-Centred Fire Risk Assessment https://www.london-fire.gov.uk/media/4844/pcra_v2-april-2020-final.pdf .

5.21 HFRS were prevented from giving advice prior to Alex's death because they had not been made aware of Alex, or given the clutter image rating scales or invited to a multi-agency forum, or asked to make a "safe and well" visit. At the time of writing this review HFRS is updating its communications to provide more detailed advice to the public and professionals in other agencies.

5.22 In conclusion, Alex smoked and was a dependent drinker. Smoking both exacerbates risks from alcohol use and introduces additional risks too. Alex had a bed in his living room where he lived and slept because he had mobility difficulties and could not get up the stairs. It appears that the fire risks from smoking and from drinking were not recognised. There was also no one assessment of Alex's ability to escape in the event of fire. The ambulance service reported various concentrations of clutter over time,

including rubbish by his bed, which they noted as a fire risk. Whilst EEAS reported this on to other agencies, such as HPFT, HFRS were never contacted for advice or to conduct a "safe and well" visit. As such opportunities for fire prevention and minimisation interventions were not taken and there was no escape plan for Alex in the event of a fire.

5.23 **Risk of Suicide**

5.24 Alex's sister told the review author that Alex had said that he would never take his own life because of the impact that this would have on his parents and because of his religious beliefs. Despite this, Alex made at least ten recorded references to suicidal thoughts or feelings between 12th April 2020 and 3rd February 2022. Alex also self-harmed/ made suicide attempts three times between 24th January 2021 and 3rd February 2022 (intentional overdose). Alex also threatened to harm himself with scissors on 22nd April 2021. Some data on the risk of suicide is shown in Appendix 7.

5.25 The Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020, sets out a number of "Risk factors and red flag warning signs" and recommends a safety plan. (See appendix 8).

5.26 Alex had contact with mental health services, but based on the information available it appears that no suicide safety plan was developed with Alex as recommended by the Royal College of Psychiatrists. On reflection HPFT suggested that Alex's suicidal ideas and thoughts were linked to his drinking rather than to acute mental health needs. Alex's sister considered that there is a need to develop approaches that comprehend both mental health and substance use. The CRHTT had not identified any signs of acute mental illness and Alex had denied suicidal ideation. The Royal College of Psychiatrists warns that a lack of suicidal ideation is not a sign of lack of suicide risk. A review of 70 major studies of suicidal thoughts (McHugh et al. 2019) showed that about 60% of people who died by suicide had denied having suicidal thoughts when asked by a psychiatrist or GP.

5.27 Handling of safeguarding concerns and other referrals

- *How effective were hospital discharge and safeguarding processes?*
- *Were any high-risk or self-neglect protocols and forums used and how effective were they?*

5.28 It is not always clear from the information provided to the SAR author which referrals made about Alex were safeguarding concerns or other types of referral. "Safeguarding" is often used as a broad, rather than as a precise technical, term. Where a referral has been specifically listed as "safeguarding" this will be made clear in this SAR report.

5.29 Under a S75 agreement (NHS Act 2006) HCC transferred its mental health social work service to HPFT and under section 113 of the Local Government Act 1972 HPFT undertakes the adult safeguarding duty under the Care Act on behalf of HCC for adults whose primary need is mental health.

5.30 As a result, safeguarding concerns involving people with mental health needs who are in contact with HPFT are often dealt with as "open" cases with reviews over time, rather than as discrete enquires in response to each concern.

5.31 HPFT is responsible for social care and safeguarding where a person's primary need is due to functional mental health problems and is responsible for commissioning packages of care for people with mental health needs following hospital discharge. However, where a person has both mental health and physical health needs the situation is more complex. Alex had physical needs due to his hip fracture which had not healed well leading to mobility problems for instance, but he also had mental health needs in the form of suicidal ideation and depression which might have contributed to his self-neglect, which in turn compounded his needs for physical care and support. The lead and funding split should be determined on a case-by-case basis depending on what the primary need of the person is.

5.32 Not all referrals about Alex's needs resulted in a response. For instance, on 21st May 2020 EEAS made a referral for a care and support needs assessment to HCC but it was determined that Alex did not meet the criteria. Alex gave permission for the ambulance crew to refer him for support with alcohol addiction and for a medication review.

5.33 There also appears to have been a disconnect in the process for s42 Care Act 2014 enquiries and s9 Care Act 2014 assessments between HPFT and Hertfordshire County Council (HCC). For example, a safeguarding concern about Alex on 1st February 2021, resulted in email exchanges between HPFT and HCC between 3rd and 9th February 2021. HCC did not believe that it had a statutory duty to assess Alex's care and support needs under Section 9 of the Care Act 2014 and HPFT argued that when not intoxicated Alex did not have mental health needs.

5.34 These discussions appear to have plateaued without any escalation to the Hertfordshire Safeguarding Adults Board Multidisciplinary Guidance for Complex Cases 2022 or recourse to multi-agency forums, for example, the Community Safety Action Group. Neither emails nor telephone contact led to any outcome. Telephone contact was at non-managerial level and an escalation of this matter to a higher level may have led to a resolution.

5.35 On 9th December 2020 the Complex Needs Service made a referral identifying that Alex's hip fracture had not healed well, resulting in poor mobility and Alex sleeping downstairs. It also noted that Alex was struggling to eat and consequently was underweight. As a result, a referral was made to Hertfordshire Care Line for an alarm pendant. Before the case was allocated EEAS sent an adult social care referral to HCC on 8th January 2020. This identified that there was no food in the house, which was very cold, and that Alex was very underweight and thin. He was covered in faeces and urine. It detailed that Alex needed help with his mental health and would like support. The referral was passed to the hospital team at WGH as Alex had been admitted. Despite this, Alex was discharged on 12th January 2021 without a care and support package.

5.36 HCC has commented that it is not clear if this is because Alex refused support. It appears, therefore, there was insufficient communication between the hospital team and HCC to ensure that the matter was properly handled and to recognise that a care and support needs assessment must be completed under S11(2)(b) if an adult refuses one and is at risk of abuse or neglect. During his time in hospital Alex had disclosed to hospital staff possible abuse (cuckooing) by his friends.

5.37 In addition, there is no record of whether the risk of experiencing abuse by returning home was considered prior to Alex's discharge on 12th January 2021. A Section 42 enquiry was commenced by HPFT and concluded on 13th January 2021. In an interview with Alex, the ACMHS established from Alex that the police were investigating alleged cuckooing and that his bank was investigating suspected unlawful access to his account. There is no evidence that the ACMHS liaised with the police for further information about this, nor was any attempt made to assess if communication barriers may have existed between Alex and the police given his history. An attempt was undertaken in the enquiry to ensure Alex was able to demonstrate an understanding of questions put to him.

5.38 There was no verbatim record of how Alex's safety was to be maintained in the future. There was however some limited discussion of "safer drinking," and the enquiry identified a neighbour who could be a protective factor preventing the consumption of alcohol. The enquiry was also assured that Alex had access to anti-craving medication, which were believed to have been stolen from him.

5.39 The enquiry was written as a case-note and had been intended to be recorded as a safeguarding record but was not. According to HPFT, this likely affected managerial oversight, making it difficult to identify any emerging patterns of abuse in the future. The enquiry was concluded proportionately in line with Alex's views. It was, however, not until 16 days later that HCC was requested to make a Section 9 Care Act 2014 assessment. HCC and HPFT could not agree who had responsibility to carry out this assessment, and consequently it was not completed. Apart from periods in hospital, this left Alex at home without support until 17th July 2021.

5.40 On 1st February 2021 a mental health social worker at HPFT raised a safeguarding concern with HCC. According to HCC the mental health social worker explained that Alex had declined support but she would find out from her manager which team should follow up. HCC closed the case as they had no further contact from HPFT. According to HPFT the mental health social worker asked her manager if she should chase HCC as she had not heard back from them, but there is no record of a reply from her manager. It appears that on the part of both HPFT and HCC there was insufficient tracking to make sure that matters were followed through.

5.41 On 14th April 2021 the police reported concerns about the condition of Alex's flat and substance misuse. An initial assessment was completed by ACMHS in response, recording Alex's views that he did not want the team to contact his GP, DBC or CGL on his behalf. Alex's sister told the review author that Alex's reluctance was due to embarrassment. HPFT has confirmed that a decision had been made under Section 42 Care Act 2014 that a duty to undertake a safeguarding enquiry had not been triggered, however this was not recorded on Alex's electronic patient record. HPFT

confirmed that the rationale for this decision was not recorded. HPFT's expectation would be for a case note to have been made explaining the rationale for the decision and detailing the alternative action being taken.

5.42 According to HPFT ACMHS empowered Alex with choice and control over which services he would engage with. Alex agreed to contact CGL independently. However, there was again no discussion of an assessment of his care and support needs or recognition of the duty to carry out a Section 9 assessment, where an individual may be at risk of abuse and neglect under Section 11(2)(b) of the Care Act. There was no safeguarding documentation for this safeguarding "episode" that would allow professionals to monitor emerging patterns of risk in his behaviours.

5.43 On 13th May 2021 HCC received a safeguarding referral from DBC stating that the police had been called and visited Alex's home. The police also sent a referral to HCC. Alex had told the police that he was being cuckooed and that his property was being used for dealing and processing drugs. The referral detailed the state of the property, and that Alex was struggling with his mobility and mental health. This referral was passed on to SPA at HPFT.

5.44 HPFT could not determine if Alex was unable to protect himself from the self-neglect, so made an "other safeguarding enquiry". This is a non-statutory enquiry and can be used when it has not been possible to satisfy all three criteria set out in Section 42 Care Act, yet there is still a need for an intervention. Information on Alex's needs and assessed risk was gathered during a home visit on 19th May 2021. An initial strategy discussion was held on 19th May 2021, and a plan was made involving DBC, the Social Prescribing Service, CGL and Alex's GP.

5.45 On 1st June 2021 a safeguarding referral was sent by Buckinghamshire Healthcare NHS Trust to HCC after Alex had called an ambulance. The referral detailed Alex's alcohol misuse and how he was immobile and underweight. This was passed to SPA at HPFT.

5.46 On 12th June 2021 HPFT converted its non-statutory enquiry into a s42 enquiry because it was believed Alex was unable to protect himself due to the impact of his alcohol use. Two case conferences were held on 14th July 2021 and on 29th July 2021, at which an unsuccessful attempt was made to involve Alex by telephone. During the multi-agency discussions there was evidence of professional curiosity about cuckooing, substance misuse and the role of Alex's friends and a neighbour. Actions from the conferences included discussing alternative housing arrangements and a deep clean of Alex's property directly with Alex. CGL completed its triage and assessment process with Alex following these conferences. The alternative housing and deep clean initiatives were pursued, but Alex was ambivalent about housing and when arrangements were put in place for a deep clean, Alex refused. Consequently, neither happened before Alex died.

5.47 Alex had attended the Emergency Departments of Watford General and Stoke Mandeville Hospitals 21 times between December 2019 and 2nd March 2022. Previous Safeguarding Adults Reviews (for example, that of Andrew, Staffordshire and Stoke, 2022 and Ms H and Ms I, London Borough of Tower Hamlets, 2020) have identified

that repeated Emergency Department hospital admissions and attendances are a potential warning sign of escalation in an adult's vulnerability (Jarvis et al, 2018) and that, for some adults at risk of abuse, hospital admissions may provide the only opportunity for safeguarding interventions to be made (Boland et al, 2014). These interventions should be made on a multi-agency basis and are more effective if they involve the vulnerable adult and their family as well as professionals.

5.48 Alex was in the ICU from 30th July until 14th October 2021, which resulted in a third case conference being cancelled. It appears that before cancelling the meeting no one sought an update about Alex's condition, nor considered whether a Care Act advocate was necessary even though Alex would have had substantial difficulties in contributing to the safeguarding process.

5.49 Alex's case however remained open but there was no contact between the hospital and HPFT about Alex's discharge date. HPFT did not seek to establish whether Alex was still in hospital until seven weeks after he had been discharged. Earlier contact would have been helpful to ensure HPFT's involvement in discharge planning and to continue the "open" case safeguarding work.

5.50 CGL closed Alex's case on 8th October 2021, after a telephone conversation with Alex, due to his length of stay in hospital. CGL supports people who are actively using substances and at this stage, Alex was abstinent. He was however discharged only a week later, but it was not until 28th February 2022, only a few days before Alex's death, that a further referral was made to CGL since he had begun to use alcohol again. Given Alex's history of self-neglect and alcohol dependency, and of health problems caused by alcohol, it would have been appropriate to take taken a more active approach to help Alex to sustain his abstinence.

5.51 Hospital admissions, no matter how long, can provide an opportunity for change: they can allow reflection, reconsideration and the engagement of other agencies including housing providers and the use of different approaches and interventions to be used after discharge. Alex's prolonged stay at Watford General Hospital was an opportunity for a multi-agency reconsideration of the effectiveness of the approaches being taken with Alex. It was an opportunity to have discussed and planned for work to, for example, encourage Alex to switching to vaping and considering alternative accommodation options which he would be discharged from hospital to, with the necessary support provided. Alex's family could also have been involved in discussions about how best to support Alex and could have been invited to work as partners in supporting Alex when he left hospital.

5.52 A review of Alex was planned for 13th December 2021, but this did not happen. HPFT explained, as part of this Review, that this was due to insufficient management oversight. At that time ACMHS were not holding their established weekly open cases tracking meetings because the team had not had a substantive senior social worker in post since October 2021. The Reviewer understands that HPFT have subsequently taken action to remedy the situation and to put in place effective processes for tracking open cases.

5.53 Other referrals

5.54 On 14th July 2021 the Out of County Hospital team sent a referral for an assessment for Alex to HCC. He had broken his arm and he needed support with washing, dressing and preparing food. Support was put in place for Alex's discharge from hospital on 17th July 2021. A food parcel was also arranged. However, this was not for long because Alex was admitted to ICU on 30th July 2021. Alex was discharged in October and refused a care package.

5.55 Alex agreed for a referral to CGL on the majority of admissions to hospital. This was in response to clinical teams recognising Alex's need for support with alcohol withdrawal and substance use, but often Alex would then decline involvement.

5.56 On 8th February 2022 ACMHS made an occupational therapy referral to ACS, but Alex died before any contact was made with him. Almost two years earlier in April 2020 EEAS has reported that Alex was using a bowl by his bedside as a toilet, and then again in April 2021. There did not appear to be any consideration that Alex might need a commode.

5.57 Contact between agencies and multi-agency working

- *How effective was multi-agency working and information sharing? Were appropriate partners engaged?*

- *How effective was communication between agencies?*

5.58 It appears that some appropriate partners were engaged, including CGL for alcohol support and mental health services. However, information was not shared with HFRS, nor were they invited to any multi-agency forum and therefore they were not engaged directly with Alex in fire safety advice, nor in supporting other agencies with co-ordinated interventions.

5.59 Opportunities were missed to involve DBC housing in particular around concerns about Alex's accommodation. For example DBC was not invited to a strategy meeting on 19th May 2021, nor to a case conference on 14th July 2021 even though concerns about Alex's living conditions were discussed in both of these meeting and recommendations about accommodation were made. At the same time, DBC was also engaged in discussions with Alex about his accommodation needs. It would have been helpful if DBC, Alex's landlord, had been involved in the strategy meetings arranged by HPFT and the resulting recommendations about accommodation. Multi-agency work should extend to all the agencies involved, including housing partners.

5.60 CGL and the Mental Health Liaison Team did work together. For example, following a safeguarding concern on 8th January 2021 there was some initial joint working between the MHLT and CGL, who agreed to visit Alex in hospital and collaboratively discuss concerns with him.

5.61 However, there were a number of instances where communication between agencies could have been improved. For example, HCC commissioned a care

package from 17th July 2021 when Alex was discharged from hospital. Shortly afterwards, and unbeknown to HCC, Alex was readmitted to hospital but three weeks later the care provider had still not reported to HCC that it had not been able to visit Alex or that it had any concerns about him or about his accommodation.

5.62 Similarly, on 9th December 2021, ACMHS established that Alex had been discharged from the ICU of WGH some seven weeks before. They had not been aware of this despite having been sent an assessment and plan by the CRHTT for Alex on 15th November 2021. ACMHS had not made direct contact with WGH during Alex's admission. Direct contact would have been helpful to ensure involvement in discharge planning and in continuing the open case safeguarding work that had been suspended while Alex was in hospital.

5.63 As well as the need for improved information sharing between agencies, the communication within agencies was not always as effective as it could have been. For example, on 1st November 2021 there was a communication breakdown between hospital teams after the MHLT at WGH requested they be contacted by the ward after Alex had finished a course of detoxification treatment. An error then appears to have occurred on the ward that led to Alex's discharge from the hospital without being seen by MHLT. ACMHS missed the plan for Alex sent to them on 15th November 2021 by CRHTT. HPFT has subsequently changed its operations to ensure that ACMHS and CRHTT complete all handovers orally to facilitate collaborative discussion and case planning to reduce the possibility of internal referrals being missed.

5.64 HPFT appears to have taken on leadership for instigating joined-up multi-agency inventions, but this declined in the latter quarter of 2021. HPFT may have recognised too slowly that current approaches were not working. This pattern of too slow recognition that current approaches are not working and of the need for multi-agency sharing of information and coordination of action is present in other SARs (Evelyn, Richmond and Wandsworth (2021), Thomas, Walsall, (2022) and Andrew, Staffordshire and Stoke, 2022).

5.65 Cuckooing

- *How was the concern that Alex's home was being cuckooed responded to?*

5.66 On 8th January 2021 a safeguarding concern was submitted to HPFT. Alex said he was frightened as his friends were using his house to use drugs. On one occasion Alex refused to allow them inside but they threatened to break down his door. Alex also said that he believed that one of his friends was stealing money by taking a bank card from his wallet. It does not appear that this was reported to the police by HPFT. However, the police had been called to Alex's house two days before where he alleged that he had been threatened with violence. The police understood that the alleged perpetrator had been taken out of the area and gave Alex advice on calling 999 should they return.

5.67 On 13th May 2021 the police and DBC worked together following a welfare visit by the police to Alex as Alex was a possible victim of cuckooing. The police noted Alex's

mobility issues, that he struggled to do housework and that his door key may have been copied by people using his flat. DBC held a tenancy enforcement case discussion resulting in recommendations to change the locks to Alex's accommodation, to make a referral to the Hertfordshire Home Safety Service (HHSS) for a security review, to make an adult safeguarding referral (following liaison with Tenancy Management Officer) including a request for an occupational therapy assessment and to notify the Community Safety Team.

5.68 There was evidence of good practice in a prompt response to the situation, considering immediate risk and ongoing needs, however there was no record made by DBC of how the cuckooing suspicions were progressed and contrary to DBC policy no copy of the referral was sent to Community Safety Team. However, the Tenancy Enforcement Officer liaised with the Tenancy Management Officer and they arranged a joint visit to see Alex.

5.69 The police made a referral to HPFT on 14th May 2021 concerning the possible cuckooing and self-neglect. The safeguarding enquiry that ensued following this referral led to two case conferences. At the second case conference police updated the enquiry that the locks on Alex's door had been changed and there had not been any further reports of cuckooing at the address.

5.70 Practitioners did not believe that Alex was entirely the victim in these circumstances. However, Alex's situation (alcohol dependency and immobility) was of a nature that may have made him an easy target for such abuse.

5.71 As already mentioned, more consideration could have been given to the risks of discharging Alex from hospital when he may have been at risk of abuse, and also to using section 11(2)(b) of the Care Act to undertake a care and support needs assessment without Alex's consent.

5.72 DBC now participates in monthly meetings specifically for cuckooing concerns chaired by the Community Safety Lead and attended by DBC housing colleagues, the police, mental health services and housing associations as required. Adult Care Services provide a monthly update on safeguarding concerns to DBC so that DBC can manage quality of referrals and provide feedback and guidance. Tasks arising from safeguarding concerns are monitored for compliance by the safeguarding lead.

5.73 **Support for alcohol use.**

5.74 While Alex was never admitted to hospital to support a planned withdrawal from alcohol, when he was admitted to hospital for other reasons he was detoxed and was supported with managing the symptoms of withdrawal.

5.75 Longer-term support was available through CGL, but was subject to Alex's consent. CGL struggled to engage with Alex. Alex had received some advice about drinking, but appeared to be ambivalent about taking up offers of help. CGL made numerous attempts to contact Alex, but often without success. There were a few face to face meetings with Alex, but most contact was attempted by telephone. It may be that measures to control the spread of Covid-19 had influenced this.

5.76 From the information provided to the SAR author it is not possible to assess the degree to which practice reflected the guidance provided by Alcohol Change for working with dependent drinkers, which includes assertive outreach. Some of the guidance was not published during part of the time period of this review. For future cases the guidance is recommended.

5.77 Alex's family

- *How were Alex's family involved and what could have been done to support them?*

5.78 Alex brother, sister and her husband all tried to support Alex. Alex's sister also telephoned services on one occasion during the period covered by this review, concerned for Alex's welfare. Alex's father and sister also telephoned Alex regularly and often every day. Alex's sister told the review author that, despite her concern for and involvement with Alex, she was told by the services that she had contacted that she was not Alex's next of kin and so could not be involved. Alex's sister felt that there should be some flexibility in involving family members more widely.

5.79 Alex stayed with his father occasionally. Alex's father was known by services to be Alex's carer, but it seems that his mother's dementia meant that his father had to reduce the amount of time he could care for Alex, so that he could provide care and support to his wife (Alex's mother). The CRHTT at HPFT made a referral to HCC for a carer's assessment for Alex's father. It is not clear whether HCC offered him an assessment and whether Alex's father took this up.

5.80 DBC Housing Department had permission to discuss Alex with his carer, his father. Other services also reported matters concerning Alex to his father. There is at least one report of Alex's father attempting to explain matters relating to services with Alex. It is probable that more could have been done to work collaboratively with Alex's family, at a multi-agency level, in attempts to improve outcomes for Alex.

5.81 In early February 2021 DBC Housing had several conversations about Alex with his father who shared the extent of some of Alex's health issues. This led to a discussion of the benefits that Alex may have been entitled to, the need for Alex's father to go through the options with Alex and a request to confirm that there was consent in place for DBC to discuss these issues with Alex's father. DBC took the time to provide documentation, resources and options for Alex's father and encouraged him to engage directly with Alex.

5.82 Alex's father was, in his late 80's and was caring for his wife who had dementia as well as providing support for Alex. According to Alex's sister, he could not have been expected to have done anymore for Alex than he was doing.

5.83 **Housing**

5.84 As Alex had mobility difficulties a move from his two-storey house to a ground floor flat would have been beneficial. There was not enough consideration given to involving DBC in multi-agency discussions about Alex's case and his mobility issues. Despite this, however DBC engaged with Alex about his accommodation. DBC discussed housing options for a move to accommodation more suited to his needs with Alex on several occasions. Alex was ambivalent at one time towards the prospect of any move and was not engaging with the social prescriber service which may have supported him to complete the necessary online paperwork. Alex's ambivalence may in part have been influenced by a convenient source of alcohol (a nearby shop sold alcohol, for example). There may have been a lack of professional curiosity as to why Alex was "in two minds" whether to move. In hindsight it may have been pertinent to determine whether he could weigh up the advantages and disadvantage of a move or benefit from practical support that would assist him in making a decision.

5.85 Mental Capacity

- *What was the understanding of Alex's mental capacity to, for example, make and implement decisions to keep himself safe and was the impact of head injuries, Vit B1 depletion, malnutrition on cognitive process (and particularly frontal lobe problems) recognised?*
- *To what extent was Alex's self-neglect recognised and understood in the context of alcohol use?*

5.86 The Mental Capacity Act (see Appendix 5) applies to the decision making of persons with "an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors".

5.87 At least 35-40% of chronic dependant drinkers have alcohol related brain injury (Wilson, 2011). Alex had diagnosed mental and behavioural disorders due to alcohol dependence syndrome, which might meet the criteria for an impairment of the mind or brain. Alex was also using drugs and alcohol which can have a coercive and controlling influence on decision making and particularly on decisions related to substance use. Substance dependency can be considered to have a coercive and controlling influence on the capacity to make decisions (for example, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/467398/Pt1_Mental_Capacity_Act_in_Practice_Accessible.pdf and London Borough of Croydon -v- CD [2019] EWHC 2943 (Fam)). It can be the cause of the impairment in the functioning of mind and brain, which forms one part of the test of mental capacity.

5.88 The ability of a person who self neglects to act on their decisions should also be considered. In Alex's case there were concerns about his ability to self-care, and to become drug and alcohol free. Whilst the Mental Capacity Act does not explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice. Further information is shown in Appendix 6.

5.89 Assessments of Alex's mental capacity to make decisions about his care and support needs tended to be made in the context of discharge from hospital. There was one

example of Alex being considered to lack capacity when he was admitted to the ICU and his best interests were met under the Deprivation of Liberty Safeguards framework.

5.90 Apart from this, practitioners working with Alex did not doubt his mental capacity to make decisions. Alex gave clear and rational insight into the impact of his drinking and was considered to be able to make decisions about the support he needed when not drinking. However this relied on interview-based questions and there was limited evidence to demonstrate that Alex's mental capacity was considered in the context of substance misuse, or a possible alcohol brain related injury, or the coercive and controlling effect of alcohol dependency.

5.91 Even if Alex had capacity to make decisions about his care, the need to intervene to protect life under the Human Rights Act (article 2) could also have been considered. Case law can be found that supports this approach (for example, Southend-On-Sea Borough Council v Meyers [2019] (EWHC 399 (Fam)). Case law can also be found, however, that defends a person's autonomy from interventions to protect their health and welfare (London Borough of Tower Hamlets and PB ([2020] EWCOP 34). This apparent ambiguity should not prevent the consideration of Human Rights Act 1998 based and interventions and possible applications to the Court of Protection when working with people who, like Alex, self-neglect and who are substance dependent.

5.92 Impact of Covid-19

5.93 There is no evidence that the Covid pandemic effected the accessibility of the acute hospital services for Alex. However, Alex's frequency of attendance (due to excessive drinking and suicidal thoughts), had increased during the lockdown period and in the Covid recovery period. This may be because community services were less accessible For example, Alex reported that CGL did not visit him at home due to Covid-19. Similarly, on 2nd July 2021 when Alex called an ambulance, he said he was struggling with his mental health and there was a lack of support from services due to Covid-19.

5.94 The responses to the pandemic, including shielding of those people who were considered to be especially vulnerable to infection meant that Alex was unable to see his mother, who had dementia, and his father who was supporting her.

5.95 Self-neglect

5.96 Alex displayed the common characteristics of a chronic dependent drinker who self-neglected. He drank large quantities of alcohol, he had physical health problems probably caused by alcohol (oesophageal tear and stricture), he had mental health problems which may have been caused, or at least exacerbated, by substance misuse (alcohol and drugs), he was not eating and was malnourished, and he was not attending to his personal hygiene and the cleanliness of his property. He was difficult to engage and when offered help he usually declined.

5.97 Alex died in a fire but his life was also potentially threatened by poor health (caused by his alcohol dependency and smoking) and self-neglect.

5.98 **Eleven themes associated with self-neglect and poor outcomes**

5.99 Alex and the response of services to him, shared a number of characteristics with the some of the eleven themes involving self-neglect identified by Patrick Hopkinson as increasing the likelihood of an individual becoming the subject of a safeguarding adults review.

5.100 Some agencies struggled to engage with Alex, self-neglect was evident, there was a suspicion that Alex was being exploited (through cuckooing), he had chronic health problems (mobility and oesophageal stricture), he had mental health needs (depression and suicidal thoughts), the ending of a relationship appeared to trigger alcohol misuse and possibly drug use, Alex had high levels of alcohol intake and there may have been an over-reliance on alcohol to explain Alex's presentation, and Alex had regular contact with emergency services. In summary Alex shared characteristics with eight out of the eleven themes identified. The other three characteristics may have been present, but insufficient detail is known.

5.101 In the light of this, Alex's case cannot be considered to be unusual or unique and his circumstances further confirm the pattern already identified.

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

5.103 **The extent to which practice with Alex was consistent with guidance on working with people who self-neglect (see Appendix 2)**

5.104 Each of the guidelines is listed in italics below, together with an analysis of the degree to which practice met the guidance.

5.105 *Seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience*. There is insufficient information to determine whether this was explored with Alex.

5.106 *Work patiently at the pace of the individual but know when to make the most of moments of motivation to secure changes.* Agencies did not make the most of Alex's long hospital stay to promote the motivation within Alex to make changes to his life. CGL closed Alex's case and it was not reopened. Subsequently, a month after he was discharged Alex said he did not want support from CGL.

5.107 *Keep constantly in view the question of the individual's mental capacity to make self-care decisions.* Practitioners did not consider the possibility of alcohol related brain injury on his capacity to make decisions.

5.108 *Communicate about risks and options with honesty and openness, particularly where coercive action is a possibility*. There is insufficient information to determine the extent to which this was done.

5.109 *Ensure that options for intervention are rooted in a sound understanding of legal powers and duties*. Insufficient attention was given to the application of the Mental Capacity Act to Alex as a dependent drinker and to Section 11 of the Care Act.

5.110 *Think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks*. More could have been done to involve Alex's family as partners in an attempt to secure better outcomes for Alex.

5.111 *Work proactively to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals.* There was some evidence of this, but the specialist expertise of HFRS was not sought and opportunities were missed to have started multi-agency collaboration at an earlier stage.

5.112 Good Practice

5.113 The Crisis Team explored Alex's support network and at a home visit considered some of the environmental challenges present.

5.114 At the S42 enquiry case conference held on 14th July 2021 there was, evidence of professional curiosity into cuckooing, substance misuse and the role of Alex's friends and a neighbour. However, there was insufficient multi-agency involvement and the conference should have included Alex's landlord, DBC.

5.115 There is evidence of good practice in the way DBC responded following contact from the police about suspected cuckooing. For example, the immediate risk to Alex and his ongoing needs were considered. DBC also responded in a compassionate way towards Alex's father when he contacted them and engaged empathetically with Alex to provide him with support, for example, around council tax when he explained he was in financial difficulty.

6.1 CONCLUSIONS

6.2 The risk posed by Alex's smoking was not recognised

- *How well were risks recognised, assessed and mitigated/ managed?*
- *Was the interrelation between, and increased risk presented by, alcohol and smoking recognised, assessed and mitigated/ managed?*
- *To what extent were appropriate harm reduction interventions attempted (fire safety, vaping, "safer drinking")*

6.3 There was a lack of awareness of the interrelationship between, and increased risk presented by, alcohol and smoking. At no point did practitioners seek advice from, or make a referral to, HFRS. Consequently, the fire risks were not assessed, mitigated and managed. There appears to have been a discussion with Alex about "safer drinking", although it is unclear whether this was in the context of fire risk or health risk. Knowledge of Alex's immobility and clutter image ratings for his home did not prompt an assessment of his ability to escape in the event of a fire and no other harm reduction interventions were attempted. Alex's sister considered that fire

safety risk recognition and response is a significant area for practice development (**Recommendation 1**).

6.4 Suicide Risk

6.5 There were numerous reports of Alex expressing suicidal ideation, and it appears he made some actual attempts to self-harm or take his own life. Alex had contact with mental health services, but no suicide safety plan was developed with Alex as recommended the Royal College of Psychiatrists. This was because mental health services considered that Alex did not have acute mental health needs, and he denied suicidal ideation when asked. **(Recommendation 2**).

6.6 **Alex's mental capacity was not considered more widely in the context of refusals of help.**

- *What was the understanding of Alex's mental capacity to, for example, make and implement decisions to keep himself safe and was the impact of head injuries, Vitamin B1 depletion, malnutrition on cognitive process (and particularly frontal lobe problems) recognised?*
- *To what extent was Alex's self-neglect recognised and understood in the context of alcohol use?*

6.7 Alex displayed the regular characteristics of a chronic dependent drinker who self-neglected. He drank large quantities of alcohol, he had physical health problems probably caused by alcohol (pulmonary abscess and oesophageal stricture), he had mental health problems which his sister considered had led to substance misuse (alcohol and drugs), he was not eating and was malnourished, and he was not attending to his personal hygiene and the cleanliness of his property. He was difficult to engage and when offered help he usually declined. Whilst Alex died in a fire, his life was also potentially threatened by poor health (caused by alcohol dependency and smoking) and self-neglect. (**Recommendation 3**).

6.8 According to HPFT staff did connect self-neglect with Alex's alcohol use. There was information sharing between, and joint assessments of Alex completed by, MHLT and CGL.

6.9 Whilst some consideration was given to Alex's mental capacity this was usually in the context of discharge from hospital and relied on interview-based questions exploring whether he could use and weigh up information. There was limited evidence to demonstrate that this was considered in the context of substance misuse, or a possible alcohol related brain injury, or the effects of alcohol dependency, and the impact this may have had on Alex's capacity to make decisions about care and support (**Recommendation 4**).

6.10 **The response to safeguarding concerns and Alex's complex needs**

- *Were any high-risk or self-neglect protocols and forums used and how effective were they?*
- *How effective were hospital discharge and safeguarding processes?*
- *How was the concern that Alex was being cuckooed responded to?*

6.11 Neither of the safeguarding referrals made in January and February 2021 resulted in the use of high-risk protocols and forums, nor did the report of a clutter rating of 7. It would appear appropriate that a multi-agency forum should have been convened at this point and had this been the case, co-ordinated interventions may have commenced earlier (**Recommendation 5**).

6.12 HCC and HPFT could not agree who had the statutory duty under Section 9 of the Care Act to complete an assessment of Alex's needs. Correspondence between HPFT and HCC did not resolve the matter. HCC and HPFT are working on a cross-service protocol to reduce the chance of this recurring.

6.13 There did not appear to be an understanding of Section 11 of the Care Act and the duty to carry out an assessment, even if Alex did not consent, if there were concerns about Alex's mental capacity to make the decision to refuse the assessment (s11(2)(a)) or that he was experiencing abuse or neglect (s11(2)(b)). An assessment under Section 11 should have been triggered on several counts 1) that Alex was self-neglecting, 2) that there was a concern that Alex was at risk of abuse (through cuckooing), and 3) that had practitioners considered frontal lobe damage they may have come to the conclusion that Alex did not have the capacity to make a decision to refuse the assessment (**Recommendation 6**)

6.14 A safeguarding referral made in May 2021, resulted in two multi-agency case conferences in July. During the multi-agency discussions there was evidence of professional curiosity about cuckooing, substance misuse and the role of Alex's friends and a neighbour. Actions from the conferences included discussing alternative housing arrangements and a deep clean of Alex's property directly with Alex. The alleged cuckooing was responded to by the police, and new locks were put on Alex's property. CGL completed its triage and assessment process with Alex following the conferences. The alternative housing and deep clean initiatives were pursued, but Alex was ambivalent about housing and when arrangements were being put in place for a deep clean, Alex refused. Consequently, neither came about before Alex died. The case conferences did not identify who was responsible for undertaking a care and support assessment under Section 9 of the Care Act. In summary multi-agency forums were not convened early enough and when they were they were only partly effective. Safeguarding case conferences would have benefitted from ensuring that all relevant agencies were included. DBC were Alex's landlord and were involved in discussions with him about his accommodation but not invited.

6.15 When Alex was admitted to the ICU from 30th July to 14th October 2021 a third safeguarding case conference was cancelled, but there was no attempt to obtain an update on Alex before cancelling, nor was consideration given to finding a Care Act advocate to represent Alex at the case conference. Alex's case remained open but there was no contact between the hospital and ACMHS about Alex's discharge date.

ACMHS did not seek to establish whether Alex was still in hospital until seven weeks after he had been discharged. Earlier contact would have been helpful to ensure ACMHS's involvement in discharge planning and to continue the "open" case safeguarding work. A review of Alex planned for 13th December did not happen due to insufficient management oversight (**Recommendation 7**).

6.16 CGL closed Alex's case on 8th October 2021, after a telephone conversation with Alex, due to his length of stay in hospital. CGL supports people who are actively using substances and at this stage, Alex was abstinent. He was however discharged only a week later, but it was not until 28th February 2022, only a few days before Alex's death, that a further referral was made to CGL since he had begun to use alcohol again. Given Alex's history of self-neglect and alcohol dependency, and of health problems caused by alcohol, it would have been appropriate to take taken a more active approach to help Alex to sustain his abstinence.

6.17 Hospital admissions, no matter how long, can provide an opportunity for change: they can allow reflection, reconsideration and the engagement of other agencies including housing providers and the use of different approaches and interventions to be used after discharge. Alex's prolonged stay at Watford General Hospital was an opportunity for a multi-agency reconsideration of the effectiveness of the approaches being taken with Alex. It was an opportunity to have discussed and planned for work to, for example, encourage Alex to switching to vaping and considering alternative accommodation options which he would be discharged from hospital to, with the necessary support provided. Alex's family could also have been involved in discussions about how best to support Alex and could have been invited to work as partners in supporting Alex when he left hospital

6.18 According to HPFT problems with the way safeguarding "episodes" were recorded made it difficult for practitioners to monitor emerging patterns of risk in Alex's behaviour. There was also a lack of a note explaining the rationale for a decision not to instigate a Section 42 enquiry. HPFT has instigated a process to improve practice in this area.

6.19 The hospital discharge process was on occasion not as robust as it should have been. On one occasion Alex was discharged without being seen by MHLT for a pre-discharge assessment. On another occasion, Alex had alleged to hospital staff that he was the victim of cuckooing by friends, but there appeared to be no consideration of whether it was safe to discharge him back home where he might be further abused (**Recommendation 8**).

6.20 How agencies worked together and the impact of Covid-19

- *How effective was multi-agency working and information sharing? Were appropriate partners engaged?*
- *How effective was communication between agencies?*
- *What impact did Covid have on individuals and the system and their responses to Alex?*

6.21 Some appropriate partners were engaged in Alex's case but HFRS and Alex's landlord were not. No referrals were made to HFRS despite reports of clutter and signs that there was a fire risk. In addition to the need for accommodation on a single floor, Alex lived opposite a shop at which he could buy alcohol, which could have indicated that an alternative location might have been beneficial. Alex's landlord was, however, not involved in consideration of the suitability of his accommodation. HPFT and CGL shared information and worked together to complete joint assessments of Alex. However, information sharing between some agencies on occasions lacked assertive follow up and monitoring. There was also evidence of some poor communication between teams within the same agency (see recommendation 1).

6.22 There is no evidence that the Covid pandemic affected the accessibility of the acute hospital services for Alex. However, Alex's frequency of attendance (due to excessive drinking and suicidal thoughts), had increased during the lockdown period and in the Covid recovery period. This may be because community services were less accessible. Alex was also unable to see his mother, who was shielding due to Covid infection risk, and his father who was supporting her.

6.23 Involvement of Alex's family

- *How were Alex's family involved and what could have been done to support them?*
- *What impact did Covid have on individuals and the system and their responses to Alex?*

6.24 Alex's sister and father were involved with Alex. His father was known to services as Alex's carer. The amount of time Alex's father could spend with Alex reduced over time when his wife (Alex's mother) developed dementia. The CRHTT at HPFT made a referral to HCC for a carer's assessment for Alex's father. It is not clear whether HCC offered him an assessment and whether Alex's father took this up. (**Recommendation 9**).

6.25 DBC Housing had several conversations about Alex with his father who shared the extent of some of Alex's health issues. This led to a discussion about the benefits that Alex may have been entitled to, the need for Alex's father to go through the options with Alex and a request to confirm that there was consent in place for DBC to discuss these issues with Alex's father. DBC took the time to provide documentation, resources and options for Alex's father and encouraged him to engage directly with Alex.

6.26 Alex's father and sister maintained regular contact with, and tried to support, Alex. However, Alex's father was in his late 80's and was also caring for his wife who had dementia. Alex's sister was not identified as Alex's next of kin and found that this prevented information about Alex from being shared with her. Alex's sister felt that there is a need for some flexibility in involving family members more widely.

7 RECOMMENDATIONS

7.1. **Recommendation 1:** (these will be turned into a checklist for relevant workforce to consider against a person presenting with these risk factors)

Partner agencies should:

a) consider how to raise awareness on an on-going basis about the interrelationship between smoking, alcohol and fire risk.

b) ensure that mental capacity assessments of smoking safety and risk is included in home fire risk awareness training. Theses risk assessments should also include consideration of sharing, with consent as necessary, fire safety concerns with landlords (where relevant to other persons placed at risk in HMOs or blocks of flats for example).

c) establish ways to promote methods of smoking cessation to multi- agency partners and practitioners.

d) work together to ensure that any hospital patient about who there are concerns of self-neglect is offered a home "safe and well" visit included as part of a discharge plan, with the "safe and well" visit completed by HFRS as soon as practicably possible after their return home.

e) ensure practitioners are aware they can make a referral on behalf of others to HFRS for a "safe and well" visit.

f) Promote HFRS "safe and well" visits to the general public.

Note: Some of these fire related actions are taken from or build upon the Sutton Safeguarding Adults Board Fire Task and Finish Group report.

7.2. **Recommendation 2**

Where an individual has a history of suicide attempts or suicidal ideation, irrespective of whether this is assessed as alcohol induced or arising from an acute mental health need, mental health services and social services in Hertfordshire should ensure that a safety plan is drawn up in conjunction with the individual in line with the recommendations of the Royal College of Psychiatrists. The plan may be shared with the consent of the individual with other agencies involved with them, where appropriate, for example, where another agency is part of the contingency arrangements within the safety plan, or is involved in supporting the individual with their welfare needs.

7.3 **Recommendation 3**

Partner agencies should consider using the "eleven themes" identified in SARs featuring self-neglect as a predictive model for identifying cases that require multi-agency input, and as appropriate include this in training to relevant staff. It may be helpful for the "eleven themes" to be incorporated into a checklist for practitioners

to identify cases of self-neglect where high risk may be present and the use of multi-agency and escalation processes might be necessary. See APPENDIX 1: Alcohol use findings from SARs.

7.4 **Recommendation 4**

Mental Capacity Act training should be tailored to specific roles and responsibilities and should include, for example, alcohol related brain injury, the effects of substance misuse and how to respond to differences between what a person does and what they do. Partner agencies may wish to audit their training current MCA training provision on this basis.

7.5 **Recommendation 5**

The HSAB should receive assurances from all partners involved in this review that they are providing training and guidance on the use of their own escalation processes or are using the newly refreshed HSAB escalation process. This could include an evaluation of how effectively they are currently working and of any barriers to staff taking the lead on escalating concerns

7.6 **Recommendation 6**

HCC and HPFT should develop guidance on the statutory duties to complete a care and support needs assessment, without consent, under Sections 11(2)(a) and 11(2)(b) of the Care Act. The guidance could also cover how these assessments could be made.

7.7 **Recommendation 7**

Partners involved in this review should use advocates if a person is unable to represent themselves in the adult safeguarding process, consistent with the requirements of the Care Act 2014, and hold safeguarding meetings even when a person is in hospital when this will support their safeguarding post-discharge.

7.8 **Recommendation 8**

The acute hospital discharge teams in association with bed management teams and Herts CC in Hertfordshire should develop a multi-agency approach to complex discharge planning. The hospitals should convene a multi-agency meeting where social complexities, and issues around mental capacity and risks which may impede a successful transfer of care or discharge to a community setting are discussed and management plans are agreed. This could include planning interventions to create the motivation within individuals to adopt less risky behaviours, such as vaping rather than smoking, when they are discharged.

7.9 **Recommendation 9**

Partner agencies should consider how they might promote working with families as partners. Carer's assessments should be offered and referrals to carer support

organisations should be made where appropriate. With due consideration given to declining such assessment in view of other recommendation to compel assessment to understand need, mitigate risks and prevent carer breakdown.

APPENDIX 1: Alcohol use findings from SARs

The Alcohol Change UK July 2019 report, "*Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017*", analysed 11 SARs and identified a number of themes common to all the reviews. Building on these, a further SAR (Andrew, Staffordshire and Stoke, 2022) identified eleven themes, which are:

- Non-engagement with services
- Self-neglect
- Exploitation of a vulnerable person
- Domestic and child abuse
- Chronic health problems
- Mental health conditions
- Traumatic events triggering alcohol intake
- Lack of family involvement
- high levels of alcohol intake and over-reliance on alcohol use to explain the adult's presentation
- regular contact with ambulance services and
- unpopularity with the local community or concerned neighbours

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

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

APPENDIX 2 Self-neglect practice guidance

Self-neglect can be defined as, "*the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecter and perhaps even to their community*" (Gibbons et al, 2006, p.16). Self-neglect is one of the ten categories of abuse and neglect specified in the adult safeguarding sections of the Care Act statutory guidance.

A summary of the practice guidance on working with people who self-neglect produced by Suzy Braye, Michael Preston-Shoot and David Orr is set out below.

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

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

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

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

The policy, procedural and organisational environments that foster effective ways of working are likely to have the following characteristics:

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

APPENDIX 3: Self neglect, mental capacity and freedom of choice

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

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

Is a person who self neglects really autonomous when:

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

Is a person who self neglects really protected when:

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

APPENDIX 4: Human Rights Act

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

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

APPENDIX 5: Mental Capacity Act

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

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

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

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

APPENDIX 6: Mental capacity - Decisional and executive capacity

There is growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation) which in turn impacts on mental capacity. Of relevance is that, compared with control groups, people with frontal lobe damage caused by alcohol use and traumatic experiences:

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

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

Significantly, these cognitive deficits are unlikely to be detected using the verbal reasoning tests frequently used in mental capacity assessments.

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

Research has shown that Vitamin B1 deficiency can lead to neurological problems such as cognitive decline. One form of Vitamin B1 deficiency called Wernicke-Korsakoff syndrome exhibits mental status changes similar to Alzheimer's disease.

APPENDIX 7: Suicide Risk

Most people who have depression do not die by suicide but having major depression does increase suicide risk compared to people without depression. Longitudinal studies have found that two percent of people who have ever been treated for depression in an outpatient setting will die by suicide (for people treated in an inpatient hospital setting, the rate of death by suicide is twice as high).

Given that at least 96% of people with depression do not die by suicide, an alternative way of considering suicide risk and depression is to examine the lives of people who have died by suicide and to identify the proportion who were depressed. From this perspective, it is

estimated that 60 percent of people who died by suicide had a mood disorder (for example depression or bipolar disorder).

Up to 10% of people with borderline personality disorder (BPD)/ Emotionally Unstable Personality Disorder (EUPD) die by suicide (Paris, 2019), which potentially makes the presence indicators of BPD/ EUPD more predictive of suicide than indicators of depression are.

APPENDIX 8: Royal College of Psychiatrists Patient Safety Report

The Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020, sets out a number of "Risk factors and red flag warning signs".

These risk factors and red flags were specifically formulated for use in primary care settings. The report cautions that risk should be assessed on an individual basis and that the absence of risk factors does not mean the absence of any risk of suicide: "*…a person may be imminently at risk of suicide even though they are not a member of a 'high-risk' group. Conversely, not all members of 'high-risk' groups are equally vulnerable to suicide. Moreover, suicidal thoughts (and risk) can vary across a relatively short time period".*

The report states that, "*…any patient with suicidal thoughts or following self-harm needs a Safety Plan. No one is ever ineligible for an intervention and Safety Plan*" and that, "*If there are red-flag warning signs/immediate risk of suicidal behaviour, the patient will require*":

- Immediate discussion with/referral to mental health services
- A robust Safety Plan
- Adequate support
- Removal of access to means

A Safety Plan is an agreed set of activities, strategies to use and people and organisations to contact for support if someone becomes suicidal, if their suicidal thoughts get worse or if they might self-harm. The components of a Safety Plan are:

- Reasons for living and/or ideas for getting through tough times
- Ways to make your situation safer
- Things to lift or calm mood
- Distractions
- Sources of support, to include anyone you trust

There is emerging evidence of the effectiveness of safety plans (Zonana et al. 2018) and it is important that Safety Plans are co-created with patients and encourage communication with family and friends.

APPENDIX 9: Suicide and Autism Spectrum

A recent SAR (Tyrone Goodyear, London Borough of Lewisham, 2020), highlighted that there was a small but growing body of research into suicide risk in adults with autism spectrum conditions and identified the following factors:

People with autism spectrum conditions have a higher rate of mortality and of suicide than the general population does.

People with autism spectrum conditions have a different risk profile for suicide compared with the general population. This includes:

A history of self-harm but not of alcohol use

Negative life experiences including:

Adversity and conflict, being victimised or bullied

- Physical or sexual abuse
- Repeated failures to develop relationships
- Depression and other mental health problems
- Isolation due to lack of social support.
- Having difficulties coping with these experiences including:
- Behaviour problems (oppositional, aggressive, angry, explosive, and impulsive behaviours),
- Having restricted patterns of thinking and lack of imagination
- Having unmet support needs
- "Camouflaging" of autism spectrum conditions.

"Camouflaging" refers to attempts to conceal autism spectrum conditions in order to fit in to social situations and is associated with suicidal behaviours even when no mental health difficulties have been identified (Cassidy et al, 2018).

People with autism spectrum conditions have an increased likelihood of experiencing the risk factors for suicidality outlined above (Pelton and Cassidy, 2017) compared with the general population. People with autism spectrum conditions also find developing coping strategies to deal with these and other life stressors more challenging due to difficulties in imagination and in thinking flexibly (Segers and Rawana, 2014).

People with autism spectrum conditions who attempted suicide (Kato et al, 2013):

- Had persistent rather than spontaneous stressors,
- Used more lethal means, and
- Were less connected to psychiatric services than people who attempted suicide but did not have autism spectrum conditions.

This increased risk of suicide is also present in people who show symptoms of, but do not have diagnosed autism spectrum conditions (Richards et al, 2019). No diagnostic assessment for risk of suicide has yet been validated on people with autism spectrum conditions (Cassidy, 2018b).

APPENDIX 10: Trauma Informed Practice

The Blue Knot Foundation has produced guidance and resources on trauma informed practice https://blueknot.org.au/resources/blue-knot-publications/guidelines/. This guidance has been adapted for the Trauma-Informed Toolkit published by the Scottish

Government https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/pages/12/#AP2 , some of which is listed below:

1) *Understand the impacts of stress on the brain*

- Under stress, we can all lose the ability to be calm, reflect and respond flexibly.

2) *Signs of trauma can take different forms*

- Trauma responses include both:
- Hyperarousal (obvious agitation, e.g. shaking, sweating, raised voice)
- and
- Hypoarousal (e.g., glazed eyes; `zoning out'; `shut down'; can be harder to detect).

3) *Simple ways to lower arousal can restore safety*

- We can all learn to do this for ourselves and others.
- Lowering arousal allows the person to return to a place where they can tolerate their feelings (`the window of tolerance') and avoid being overwhelmed from hyper- and hypoarousal.

4) *Challenging responses and behaviours can be defences against stress*

- Traumatised people develop coping strategies to protect them from being overwhelmed.
- Understanding this allows us to consider what may have `happened to' a person rather than what is `wrong' with a person.

5) *The `way in which' we interact with a traumatised person (not just `what' we say and do) is important*

- It can also either increase or decrease a person's stress levels. This underlines the importance of knowing how to interact in a trauma-informed way, not make things worse, and `do no harm'.

6) Understanding the stress response

Hyp*er*arousal
- Increased heart rate
- Increased rate of breathing
- Blood flows from the arms and legs to organs and major muscle groups
- Tension in the person's muscles
- Hypervigilance i.e., being on guard (for threat)
- Problems with the digestive system
- Disturbance of sleep and energy levels

Hyp*o*arousal
- Having feelings of being 'shut down' or 'cut off'

- Avoidant – avoiding places, events, feelings
- Withdrawn
- Loss of humour, motivation, pleasure and connection with others
- Disturbance of sleep and energy levels

7) Tips to reduce stress

Hyp*er*arousal

- Recognise being hyper-aroused is a distress/fear response
- Validate their response ('I can see you are...')
- Support the person to feel safe
- Turn the person's focus to their current need/task
- Support gentle ways for the person to release some energy
- Help the person to feel grounded, and feel settled in their body (e.g. feet firmly on the floor; some stretches)

Hy*po*arousal

- Recognise being hypo-aroused is a distress/fear response.
- Support the person to feel safe.
- Provide an opportunity for the person to express their current needs without pressuring them to do so.
- Pay attention to the physical space (more or less proximity to others?).
- Help the person to become aware of their current surroundings and to tune into their senses.
- Encourage the person to move a little, change their posture/position or practice a familiar ritual or rhythm. Emphasis should be on movement rather than sensations for hypo-aroused states.
- Direct attention outward (e.g., noticing objects in the room) rather than inward.

APPENDIX 11

Alcohol Change UK's guidance on How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales produced by Professor Michael Preston-Shoot and Mike Ward, August 2021, describes common myths or misconceptions identified by professionals about the use of legal powers with dependent drinkers that impede their care.

"One: If someone says they don't have a problem and doesn't want help, there is nothing we can do.
Two: If the person is choosing to live like this, or likes living like this, we can't define them as vulnerable.
Three: A person is not vulnerable or self-neglecting if they have mental capacity.
Four: Once someone is sober they no longer lack capacity or have care and support needs.
Five: If a person has capacity, there is nothing we can do.
Six: A person has the right to make unwise decisions.
Seven: Alcohol dependency is not covered by the Mental Health Act.
Eight: Mental health services don't need to assess someone if the main problem is alcohol.
Nine: Assessment is impossible if someone never turns up for their appointments.
Ten: A person can't be assessed if they are always intoxicated.

Eleven: There is no treatment available for vulnerable dependent drinkers, so people can't be treated under the Mental Health Act.
Twelve: Once someone stops drinking the problems always go away, so this isn't a mental health issue."

The guidance document dispels these myths and misconceptions and provides examples of the positive use of legal powers with chronic dependent drinkers.

The guidance document provides a "Working with drinkers" checklist, as follows:

"Have I taken the time needed to assess the person I'm supporting, usually across multiple meetings, at least once in their home?

Have I expressed "concerned curiosity" characterised by gentle persistence, skilled questioning, conveyed empathy and genuine relationship-building?

Have I undertaken a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes?

Have I undertaken a thorough mental capacity assessment, which includes understanding and consideration of executive capacity, recognising being articulate and scoring well in cognition tests can mask difficulties?

Have I undertaken a thorough mental health assessment, with particular attention at points of transition, for example hospital discharge or placement in supported accommodation?

Have I undertaken a comprehensive risk assessment, especially in situations of service refusal?

Have I avoided assuming that negative behaviour are a "lifestyle choice" and developed a deeper understanding of what might lie behind their refusal to engage, for example loss, trauma, shame and fear?

Have taken the time to consider the impact of adverse experiences, including those of loss and trauma, and explored any repetitive patterns?

Have I understood how the person's faith, age, gender sexuality and ethnicity may be impacting on the nature and presentation of their needs?

Have I recognised the person's assets as well as their needs and risks?

Have I used a person-centred approach that demonstrates proactive rather than reactive engagement?

Have I considered whether and how family involvement may be of benefit, to both the drinker and to them?

Have I considered how to ensure our response is creative, for example making use of peer support, text messaging, online technology, playfulness, etc?

Have I maintained contact and been reliable, even when the person appears not to be engaging?"

This guidance document was available for only the last seven months of Alex's life, but as the purpose of this SAR is for services to learn and develop, the contents of the guidance are relevant and are included in recommendations.

APPENDIX 12: Literature review

The literature review was conducted using the following resources:

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

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