Wakefield & District Safeguarding Adults Board

Safeguarding Adults Review in respect of Steven

Author: Mike Ward
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Foreword by the Wakefield and District Safeguarding Adults Board (WDSAB) Independent Chair

Steven was a 43-year-old man who was referred to the Wakefield and District Safeguarding Adults Board for a Safeguarding Adult Review (SAR) by a local drug and alcohol service. Their referral indicated that they believed that there were major lessons to be learned from the review of his death. The service was clear that issues identified in a SAR would not be isolated incidents.

Readers may not be yet aware that Wakefield has an above average drug and alcohol death rate and so it was important to the Safeguarding Adults Board that we identified a leading expert in drug and alcohol services and care. Mike Ward has undertaken this review with sensitivity and a desire to ensure that in Wakefield we learn from Steven's untimely death and go forward and improve care and services for others struggling with the same or similar issues to Steven. Thank you, Mike, for your leadership and approach to this work on behalf of the board and the future service users in Wakefield

I want to thank Steven's sister for contributing to this review and from her we have learnt much regarding Steven as an individual. I want to thank all of the practitioners who both attended workshops and provided information to the review.

The review outlines some of the good practice by services and the acknowledgement by services that improvements can be made. Readers will see that there are a number of improvements to be made and the Safeguarding Adult's Board will work with others as indicated to make sure this work is taken forward in a professional and timely way so that Steven's death was not in vain.

Diane Hampshire
Independent Chair Wakefield and District Safeguarding Adults Board.

Introduction

Steven was a 43-year-old White British man living in Wakefield with both an alcohol and drug use disorder. He had a history of depression and suicidal ideation, along with several serious health conditions. He was living in Housing Association accommodation. He was found dead in the street in November 2022 after having been taken to Hospital by Ambulance the previous day because of concerns about infected staples in his leg and his current poor living conditions.

However, he left the Hospital before receiving any treatment. He subsequently purchased alcohol from a nearby off licence and was seen on CCTV to be unsteady on his feet. He remained sitting on a wall near the Hospital for several hours drinking alcohol. The next day he was found on the ground alongside the same wall. Concerns from passers-by eventually led to paramedics being called and he was pronounced dead that afternoon.

Toxicology analysis after his death revealed profound and potentially fatal alcohol intoxication along with the presence of methadone, mirtazapine, cocaine and cannabis. The Coroner recorded his death as alcohol-related. The main cause of death was acute respiratory failure with pneumonia, asthma, ethanol toxicity and methadone use as additional factors.

A referral for a Safeguarding Adults Review (SAR) was made by the local Alcohol and Drug Service. They felt that Steven's death was avoidable, and that there were "major lessons" to be learnt from it in relation to missed opportunities to provide Steven with essential care. The service also stated that these challenges were not an "isolated experience" and that their clients and staff experience them "on a regular basis". The original SAR referral also raised the possibility of "organisational abuse" in relation to his engagement with the Acute Hospital and other services.

This request was considered and it was agreed by the SAR panel in April 2023 that a mandatory SAR would be undertaken. It was decided that the focus would be on a period from November 2019, when Steven moved to Wakefield, until his death three years later.

1. Purpose of the Safeguarding Adults Review

The purpose of SARs is to gain, as far as possible, a common understanding of the circumstances surrounding the death of an individual and to identify if partner agencies, individually and collectively, could have worked more effectively. The purpose of a SAR is not to re-investigate or to apportion blame, undertake human resources duties or establish how someone died. Its purpose is:

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults.
- To review the effectiveness of procedures both multi-agency and those of individual agencies.
- To inform and improve local inter-agency practice.
- To improve practice by acting on learning (developing best practice).
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

There is a strong focus on understanding issues that informed agency/professional's actions and what, if anything, prevented them from being able to properly help and protect Steven from harm.

2. Independent Review

Mike Ward was commissioned to write the overview report. He has been the author of fifteen SARs as well as drug and alcohol death reviews and a member of a mental health homicide inquiry team. He worked in Adult Social Care for many years but in the last decade has worked mainly on developing responses to change resistant dependent drinkers.

3. Methodology

A multi-agency panel of the Wakefield Safeguarding Adult Board was set up to oversee the SAR and commissioned the author to complete the review. Initial information was sought from agencies involved with Steven using the SAB's Individual Management Report form. This seeks information on the individual, a chronology and analysis of agency involvement.

Some of the information provided includes information from outside the time period identified enabling a fuller picture of Steven to be developed. In particular, information from his sister.

The following agencies were involved in the process:

- Adult Social Care, Wakefield Council
- Health Centre 1 (May 2022-September 2022)
- GP Surgery 1 (October 2021-May 2022)
- GP Surgery 2 (November 2019-October 2021)
- Local Care Direct Out of Hours
- Yorkshire Ambulance Service
- Mid-Yorkshire Teaching Trust (MYTT)
- South West Yorkshire NHS Foundation Trust (SWYFT)

- West Yorkshire Police
- BridgeIT Housing – supported accommodation provider
- The Saviour Trust
- Housing Needs Service, Wakefield Council
- Turning Point – Alcohol and Drug Service
- Department for Work and Pensions

In December 2023, a Practitioners' Workshop was held to consult those who had worked with Steven or had other insights into his life. All of this information was analysed by the author and an initial draft of this report was produced and went to the Review Panel in December 2023. Further changes were made over the next two months, and a final draft was completed in January 2024.

4. Family contact

An important element of any SAR process is contact with family. Steven had two sisters. One of them was contacted to engage her in the process; she contributed through a phone conversation with the author. He is profoundly grateful for her helpful insights into her brother's life. These have informed this process.

5. Parallel processes

There were no parallel processes such as Police or Coronial inquiries that coincided with the review process.

6. Background and personal Information

At the time of his death, Steven was a 43 year old man who was living in supported accommodation. He had alcohol and drug use disorders and, in addition, a diagnosis of depression and mixed anxiety and depressive disorder. He also had diagnoses of alcoholic gastritis, liver problems, asthma, an enlarged heart and carpal tunnel syndrome.

His mother died during the review period. This seems to have had a very negative effect on Steven and may have contributed to his low mood in the last years of his life. He is survived by his father and two sisters. The latter were supportive of him in the period under review, but he had limited contact with his father. His family described his upbringing as *"not brilliant"* and reported violence within the family towards Steven. He began to drink cider and use painkillers from the age of 15. His family felt that he had *"something wrong with him";* and suggested ADHD or Aspergers. However, this is the only reference to such a condition; it does not appear in professionals' notes.

He described himself as a *"ladies' man".* He never married but he did have a couple of longer term relationships with women. One of these was with another heroin user and whose impact on Steven was described negatively by his family. A second relationship was more positive for him. However, in the period under review, although he may have had girlfriends, there is no evidence of a particular partner in his life.

Workers who knew him, and his family members, described him as a friendly man who was a good musician and artist. He had studied art at college in Wakefield and had been part of a club/party scene in Leeds when he was younger. He was an intelligent man and at one time worked in a bank. His very individual dress style was commented on – an apparent cross between Rastafarian and goth which made him distinctive in the local area. One worker said he was known as *"Jesus"* because of his dress style. He is also reported to have spoken with *"a Caribbean accent which lapsed from time to time into Yorkshire".* One worker who knew him well said *"He was a clever lad…I really liked the guy, he was smartish and we could have helped him."* This worker emphasised that Steven did want to escape the problems he was having with alcohol and drugs: *"he was really trying"*. He attended a local church and reported conversations about his drinking with his pastor.

Prior to 2019, he was living in Leeds but from March 2020 until April 2022, he lived in accommodation provided by a local homelessness charity. Immediately prior to that he was street homeless. He is reported to have had good support from his worker there and there was good liaison between Steven's worker and the Alcohol and Drug Service. However, he lost his place due to complaints from fellow residents (including threatening a fellow housemate) and became homeless before moving into a unit provided by another housing provider where he lived until his death. The Manager of the first unit blamed a large back payment of benefits (PIP) which led to "hangers on" gathering around him for his money and causing his commitment to sobriety to decline.

Adult Social Care undertook a Care Act assessment with Steven in April 2021. The Social Worker liaised with Steven's sister, the Alcohol and Drug Service and the Live Well service. This was concluded in May 2021 with "no eligible Care Act needs evidenced".

In August 2021, Steven was arrested for possession of a firearm and was released on bail. Steven stated that this was a pellet gun which was not loaded. Nonetheless, the view was that this could have caused alarm, especially in the hands of an intoxicated individual.

However, although Steven could be threatening to others, he was probably more frequently targeted by others due to his vulnerabilities. There are Police and other reports with Steven as the victim: but he did not pursue these reports. In 2021 he attended Hospital as a result of bruising that he said was caused by a girlfriend. He was also assaulted, and had property damaged, by a boyfriend of a woman he knew.

In May 2022, Steven reported that he thought that he had been spiked with Pregabalin by someone who was known to do this to vulnerable people. He reported that the same person

had stolen his bank card, phone, and money. Steven confirmed that he had the bank card blocked and requested a new card without a contactless facility on it. In September 2022, the physical injuries that led to his final Hospital attendances were the results of an assault.

At the time of his death, the Alcohol and Drug Service were prescribing a daily dose of methadone (physeptone). Methadone is a synthetic opiate used in opiate substitution treatment with heroin users and reflects that heroin had been a problem for Steven. He also reported occasional use of crack or cocaine. However, in the last year or two of his life it appears that alcohol was causing him more problems than illegal drugs.

In April 2022, he was drinking 7-8 cans of lager per day (approximately 16 units). He was engaging with the Alcohol and Drug Service and working towards an alcohol detoxification. He was also attending their alcohol groups, although he did miss occasionally. However, at this point he became homeless again and as a result was very difficult to engage and lost contact with the service. By the time he found stable accommodation again and was in touch with the Alcohol and Drug Service, he was drinking 6-8 litres of 7.5% cider daily (39-60 units). He described drinking on waking and that he had had seizures in the past: indicative of dependent drinking.

Steven had a history of suicidal ideation and his last risk assessment by the Alcohol and Drug Service (September 2022) indicated current suicidal thoughts. He had previously deliberately walked in front of a car. However, Steven denied having suicidal thoughts during a home visit in October 2022. In general, the practitioner's event suggested that the major problem for Steven was substances rather than his mental health. Workers believed that his generalised low mood may have been the result of his alcohol use. He had very limited contact with secondary care Mental Health Services, however, he was being prescribed Mirtazapine (an antidepressant) by his GP.

He was admitted to Hospital in early June 2022 with a gastro-intestinal bleed. He had blood tests and x-rays but he self-discharged. While there he was given Librium (a benzodiazepine used in alcohol detoxification) and Pabrinex (vitamin therapy commonly used with dependent drinkers to reduce brain damage).

In mid-June 2022 an Alcohol Practitioner had a "frank discussion" with Steven about the acute risk to his health and life-expectancy if he continued drinking alcohol. A plan to reduce his drinking was discussed with the aim of working towards a detoxification. This would have needed to be an inpatient detoxification due to a history of alcohol-related seizures. He was also advised of the need for an endoscopy as his liver disease may have been progressing to cirrhosis.

Over the next three months Steven was described by the Alcohol and Drug services as "difficult to engage".

In September 2022, Steven attended a face to face Recovery Worker appointment at the Alcohol and Drug Service. A 12 week review and risk assessment was completed. Steven was intoxicated and speaking in 'a confused way'. He reported a range of physical problems: 'cirrhosis of the liver, coughing up blood and being unable to retain water'. He also reported 'occasional' use of cocaine but would not state frequency or quantity'. However, the 'main issue' was his alcohol use. He was typically drinking three 2.5 litre bottles of 7.5% ABV cider daily (50-60units). At this point his medication was reported as mirtazapine, thiamine and lansoprazole (to reduce gastric acid).

On 22 November 2022 Steven was found dead in a public place near the Acute Hospital following an A&E attendance the previous day. The events of the intervening two to three months are central to this review and are dealt with in section 9.

7. Professional curiosity - understanding Steven's presentation

Steven's history highlights the importance of professional curiosity. Given the repeated pattern of self-neglect and service refusal, practitioners needed to understand what lay behind this challenging presentation. It was very easy to see the behaviour as simply the result of his substance misuse. However, professional curiosity could have suggested that there was far more to Steven's behaviour and, therefore, have driven a far more intensive or coordinated approach.[1] Four particular themes are relevant with Steven:

- Cognitive impairment
- Liver disease
- Being the victim of abuse
- Trauma.

(Again it is also worth noting that his family felt that he might have an Autism Spectrum Disorder: but there is no more detail on this.)

With any chronic dependent drinker, there is a risk of cognitive impairment, particularly as a result of vitamin B1 deficiency – a side effect of heavy drinking. The Practitioners' Workshop was clear in stating that professionals did not think that he had cognitive damage. Yet the notes on the case are more ambivalent.

Steven had had seizures in the past and had experienced head injuries as a result of violence. These could have added to cognitive damage. He had had multiple detoxifications which could generate kindling – increasing physical and cognitive damage as a result of repeated detoxification.

What is more relevant is that the Alcohol and Drug Service notes express concerns about his cognition:

[1] This can be called *diagnostic overshadowing* – where everything gets blamed on the alcohol.

- *February 2021 - Steven attended the service… and…was asked if he remembered the telephone conversations that took place that day. Steven reported he did not and that he had problems with his memory, which he linked to his alcohol use.*
- *March 2021 - Wellbeing review completed and Pabrinex score indicated the need, so it was arranged for Steven to attend service for a course of Pabrinex.*
- *April 2021 - The Social Worker from Social Care Direct advised that Steven would need to speak to a doctor at a memory clinic, who would then assess and refer depending on the need.*
- *April 2021 - Steven felt as though his memory was deteriorating and at times could not find his way back to his accommodation due to this.*
- *May 2021 - Prescribing review completed with Clinical Operations Lead. Notes stated concerns of memory loss and significant risk of Korsakoffs.*

Beyond cognitive damage, liver disease can cause fatigue and low energy levels. This could have been a factor impacting on his motivation and ability to engage.

Trauma and abuse could also have had an impact on him. His family described childhood abuse. Two more recent significant traumatic events are identified in the agency reports: the death of his mother and that he was the witness of a homicide and had to participate in the subsequent court case (2021). Section 7 has highlighted that Steven was a victim of abuse from others.

All of these factors highlight that there may be more to his presentation than simply substance use. Other factors *could* be driving his difficult and challenging behaviour. This review cannot diagnose or re-diagnose Steven. However, his history should raise questions about his cognition and other physical impacts, and be a reminder to all professionals of the importance of considering the impact of cognitive damage, particularly with dependent drinkers. Professionals need to use professional curiosity to understand what other factors may be impacting on his presentation.

8. The last three months of Steven's life.

8.1 The events of the period

In mid to late September 2022 Steven was attacked and suffered a fracture to his right arm and, more significantly, a leg fracture. At this point he also had a fractured wrist which was sustained in August (whilst breaking up a fight). The leg injury led to him being hospitalised. The Alcohol and Drug Service learned of this when the Hospital made contact (22/9/22) about his medication details. The fracture required an operation and the Alcohol and Drug Service were concerned that the Hospital were made aware of Steven's alcohol dependency, alcohol liver disease and that he had been having gastro-intestinal bleeds. The Doctor they spoke to confirmed that he would pass the information on to the Consultant.

Six days later, the Alcohol and Drug Service made contact with the Hospital for an update and was informed that Steven had self-discharged on the 23/09/22. There was no discharge summary and no contact from the client to the Alcohol and Drug Service. The Recovery Worker attempted to call him but his phone was switched off, so a text was sent requesting contact. The worker then called the Pharmacy who were able to inform them that Steven had collected his script that day but had missed the two previous days.

The next day (30/9/22), an Alcohol and Drug Worker contacted the Community Pharmacist and discussed their concerns for Steven. The Pharmacist reported that he had 'looked visibly distressed…on crutches' and felt that he would struggle to attend the service due to the injuries to his leg and arm. It was agreed that the client's script would be delivered daily by the Pharmacy to the client as a short-term plan while the service assessed him. A home visit was to be arranged as soon as possible and it was noted that Steven was 'on a low… and therefore safe to continue…dose of 40ml'.

The Alcohol and Drug Service tried to contact Steven on 6/10/22 but the call went to voicemail. On 17/10/22, the Alcohol and Drug Worker contacted the Hospital and spoke to the Fracture Clinic in relation to his wrist injury appointments as he currently had no phone. It was reported that Steven had been discharged due to not attending three appointments. However, it was noted that in addition to the client having no phone, the Hospital notes had the incorrect address for the client. The worker told the Fracture Clinic (who were working on his wrist injury) that Steven still had staples in his leg and was advised that Steven would need to attend his GP surgery or for a District Nurse referral to be made. The Alcohol and Drug Worker referred him to the District Nurse Team.

The next day the Alcohol and Drug Worker went to visit Steven at home to complete a welfare check and review his medication. Steven was on 40ml methadone at this point which was reported to be satisfactory for him. He was drinking around 6-7 500 ml cans of 7.5% ABV cider (26.2 units) and smoking two cannabis joints daily.

Steven reported that he had discharged himself from Hospital as he was not given his methadone or Librium. The Alcohol and Drug Workers noted that the client was supposed to have had a Fracture Clinic review but that Hospital Transport did not arrive. At this stage Steven had poor mobility, was non-weight bearing and using a Zimmer frame. However, the worker stated that, on the whole, Steven was looking 'brighter' than compared to their last review and his reported alcohol intake was 'down' and his housing was now 'stable'.

On 19/10/22 the Alcohol and Drug Service referred Steven to the Community Nursing Service for removal of his staples. He did not attend any of the appointments made for him at community locations and this was subsequently closed and referred back to the GP. The staples were therefore left in for a prolonged period of time and became infected.

On 8/11/22, the Alcohol and Drug Service contacted Steven's pharmacy to leave a message asking him to make contact with the service as his phone was not working. On 15/11/22 the

Alcohol and Drug Service received a call from a Housing Support Worker who was with him and was concerned that the staples in his leg had not been removed and 'look sore and swollen'. The Alcohol and Drug Worker advised that Steven should attend the GP or Hospital and reassured him that they could liaise with the Hospital to ensure that he would receive his prescription there. Steven was reluctant to go that day and stated that he would go the following day. The worker emphasised the high risk of infection, potential sepsis and possible loss of a limb (Steven was already reporting having a fever). The Housing Worker said she would attempt to take him to Hospital and provide an update the following day.

The next morning, Steven was dropped off at A&E. He had taken 10 cans of beer, stating that if he wasn't allowed to drink or be given Librium then he would leave. The Housing Worker stated she would go to see him the following day and update the Alcohol and Drug Service. However, Steven did not stay for treatment.

Two days later (18/11/22), the Social Worker at the Alcohol and Drug Service had a telephone call with the duty GP at Steven's surgery. The concerns about Steven's health risk were shared and also the view that he may lack the capacity to make a decision about going to Hospital. The Social Worker suggested that it was the GP's responsibility to assess capacity and make a 'best interest decision' about his Hospital admission. The GP suggested it should be the Social Worker that leads on this. The Social Worker disagreed because it was a medical decision. The GP stated that they were not an emergency service and that an Ambulance should be called. The Social Worker informed the GP that an ambulance had been called (more than once) and that the client had refused to go to Hospital and paramedics had not made him go.

The GP stated that the District Nurse was due to visit the client the following day and would be able to feed back to the GP if there were any concerns. However, the Social Worker stressed that the risks were more urgent and requested an intervention that day. He gave the contact number of the Housing Worker to the GP but it transpired that the worker had left for the day. The Social Worker requested that someone from the Housing Service contact the GP to express their concerns about the client and also suggested that if they were questioning his capacity, they should explain this to the GP.

Later, it was learned that Steven had been admitted to Hospital because another Ambulance had been called. However, Steven discharged himself without having the staples removed from his leg. The Housing Worker reported to the Alcohol and Drug Service that Steven was 'visibly unwell' and that they were going to call an Ambulance because of concerns that he could have sepsis'.

The Alcohol and Drug Service later received a call from the Housing Worker stating that the client *'appeared to have soiled himself and urinated on himself. He appears to be slumped in the same position and same clothes as they saw him in on Friday and the room smells terrible.' The client was reporting to be in pain but had refused an ambulance again and had not taken any of his antibiotics. He was reported as 'coughing up orange/yellow bile and*

spitting on floor and has not eaten in days.' The Housing Worker stated that she would update the Alcohol and Drug Service after checking on him again that afternoon, which she did, stating that Steven had again been taken to Hospital. The Housing Worker stated that the plan was to house the client in a 24 hour Support Hostel on his discharge from Hospital. At this point he was walking with a Zimmer frame.

He entered Hospital at 15.07 on 21/11/22. On 22/11/22, the Alcohol and Drug Service received a call from the Housing Worker stating that she had been informed that Steven walked out of Hospital at 17:27 the previous day without being treated and had subsequently not been seen. The Housing Worker had rung the Police and informed them he was missing and mentally unwell. She stated that the Police had put him down as a low risk missing person.

The Alcohol and Drug Service contacted the chemist to void the existing script due to not knowing if he had been taking it or not. The Service's Social Worker contacted the Hospital Safeguarding Team, the Police and the District Nurse service to inform them of acute concerns for the client (staples still not removed, suspected sepsis, alcohol dependent).

The Police escalated the concern to an Inspector for a decision on priority. The District Nursing team would not bring a home visit forward and suggested that the GP should be contacted. However, Steven had already died that day, his body being discovered at around 3pm.

In fact, Steven had walked to the closest off-licence and was found dead the following day outside those premises. It is reported that the location was somewhat obscured which explains why his body was not found sooner.

The provisional cause of death provided on the SAR referral was sepsis, but a post-mortem confirmed the cause of death as acute respiratory failure (1a) and pneumonia, asthma, ethanol toxicity, methadone use (1b). Steven's death has been reported to the coroner.

8.2 Learning from this period

This three month period was the main focus for the SAR referral and for subsequent discussions, such as those in the Practitioners' Workshop. This major section of the report looks at a number themes that emerge from this period:

- Process within the Hospital
- Mental capacity
- Organisational abuse
- Unconscious bias
- The management of dependent drinkers in Emergency Departments
- The role of Alcohol Liaison Teams

8.3 Process

Steven's final 24 hours raise a process question:

- Was his current situation linked to past failed attendances to engage with medical care and the seriousness of his medical situation?

The Hospital notes on his final attendance read simply: *"ED attendance brought in by Ambulance Service. NEWS2=4[2]. Had leg surgery post assault in September. Clips remain in situ. Removal refused. Not moved from sofa at home. Decline in mental health. Bloods taken, did not wait for clinical assessment. Steven assessed as having capacity."*

Information provided for the initial fact find provides more detail: *21/11/2022 – Attended … ED at 15:07 via ambulance – left before being seen – patient informed staff that he was going outside for a cigarette at 16:00, the discharge letter states that the patient was confused but there was no evidence in the patient's notes to state that his absence had been reported to any other agencies. Deemed to have capacity to consent to triage assessment prior to going outside.*

Steven had had a series of recent failed engagements with Acute Trust services both in Hospital and in the community. The Trust also held information on the seriousness of his health situation, in particular the risk of sepsis. It is not clear that this information informed the interventions with Steven at the end of his life. Given that he was known to be seriously at risk and difficult to engage, should a more robust approach have been used to manage his attendance on 21st November?

It is acknowledged that Steven may also have been challenging to assess and treat, that Emergency Departments are very busy environments and that there may have been other patients requiring urgent attention. The question remains: were people involved in Steven's care aware of, and did they use, this information as part of their decision-making? If not, does that highlight a process issue that needs to be addressed? Does a client in Steven's situation require some kind of flagging to raise awareness of the seriousness of this condition and the challenges he will pose. Should his case have been escalated at an earlier stage to the High Intensity User Group meeting, which would have flagged him as someone needing a more tailored response? It was ultimately very predictable that Steven would leave.

Steven's engagement with the Emergency Department also raised questions about information-sharing when he left. At the very end of his life it is a moot point whether raising him as a missing person with the Police would have been beneficial. However, it is

[2] NEWS is National Early Warning Score systems that alerts health providers to deteriorating adult patients in Hospital. A score of 4 is low risk and requires prompt assessment by ward nurse to decide on change to frequency of monitoring or escalation of clinical care. Within that, a score of 3 on any one measure requires urgent review by ward based doctor to determine cause and to decide on change to frequency of monitoring or escalation of clinical care

noticeable that when he left Hospital in September, there was no communication with the Alcohol and Drug Service despite their input to the Hospital on his prescribing regime.

This whole incident suggests that a review should be undertaken of how the Emergency Department can manage vulnerable and difficult to engage people in the future. This should address the questions outlined above including how information about vulnerable individuals is used within the Hospital e.g. were staff aware of his risk of sepsis and his previous history of disengagement? When should they be referred to the High Intensity User Group? How and when should information be shared on to other agencies from the Emergency Department? (The more specific issue of mental capacity is addressed immediately below).

8.4 Mental Capacity

The agency reports mention mental capacity on a number of occasions. However, up until the last 24 hours of his life, agencies such as the Ambulance Service or the Hospital viewed his refusals of care as being capacitous.

The key issue is Steven's capacity to discharge himself from the Hospital on 21st November. The Hospital notes quoted in the previous section suggest that he was assessed as "having capacity" during this brief stay, although separate information suggests that the capacity decision was about his ability to engage in a triage assessment rather than the more relevant consideration of his ability to make decisions about his health and wellbeing. Moreover the notes suggest that Steven left fairly swiftly without much engagement with staff. It is unclear from the notes whether a decision was taken that Steven had the capacity to decide to leave or whether Hospital staff were simply not sighted on Steven and his situation and, therefore, unaware of the significance of his departure.

This raises issues about the use of the Mental Capacity framework in the Hospital. In particular, it highlights the importance of staff considering executive capacity in such circumstances.

In assessing capacity with vulnerable and self-neglecting individuals like Steven it is important to consider executive function. The Teeswide Carol SAR (about a chronic dependent drinker) talks about the need to look at someone's "executive capacity" as well as their "decisional capacity". Can someone both *make* a decision and *put it into effect* (i.e. use information)? This will necessitate a longer-term view when assessing capacity with someone like Steven. Repeated refusals of care, as happened with him, should raise questions about the ability to *execute* decisions. The draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function and to consider repeated failed decisions when assessing capacity.

It is not clear that Steven's departure from Hospital was the result of a specific mental capacity decision. However, the last three months of his life highlight the importance of

considering executive capacity. This was supported by the Practitioners' Workshop and clearly represents a professional development issue.

8.5 Managing withdrawals in the Emergency Department

The original SAR referral raised by the Alcohol and Drug Service suggested that "organisational abuse" contributed to Steven's death. This is in respect of systems and processes, rather than any deliberate actions by a specific service. The "abuse" relates to barriers Steven and those supporting him experienced when trying to access healthcare appropriately and safely. The possible organisational abuse is in relation to four services: the Hospital, Community Nursing, Primary Care and Adult Social Care. This section considers this issue in the context of the Hospital.

The SAR referral suggests that the Hospital was not making appropriate adjustments to allow someone with an alcohol dependency to safely wait in the Emergency Department without risking alcohol withdrawals. This fear was seen as a real reason why *"Steven and other dependent drinkers would feel the need to discharge themselves in order to self-manage their withdrawal symptoms."*

The information provided by the Hospital Trust indicates that Steven had attended the Emergency Department multiple times during 2022, but regularly left before being seen. In June 2022, he was "observed to be drinking vodka on Hospital grounds, he refused to stop drinking and requested to self-discharge". After his operation in September 2022, he is recorded as self-discharging due to delays in receiving methadone. This does support the contention in the SAR referral.

This is not a local issue. These same processes will be happening in Hospital's across the country. The Department of Health's draft Clinical Guidelines[3] address the issue of detoxification in the Hospital setting; but they do not address this very specific theme. Therefore this is an issue which would benefit greatly from national guidance, but may need to be the subject of local guidance in the short term.

The author consulted a leading Alcohol Liaison Nurse (a former Nursing Times Nurse of the Year for Alcohol Liaison work) on what should happen in this situation. He acknowledged the lack of specific guidance and the need for local protocols. However, in the short term he suggested that at an earlier stage a multi-disciplinary team meeting should have been convened and put a plan in place for next time he came in to the ED and is at risk of withdrawals. This did not occur with Steven, and it could have benefited him.

[3] https://www.gov.uk/government/consultations/uk-clinical-guidelines-for-alcohol-treatment

8.6 Unconscious bias

The SAR referral also suggests that Steven and other clients may have been reluctant to attend Hospital due to feeling judged and discriminated against due to their "drug or alcohol seeking behaviour". It is very hard to draw a line between what ultimately happened to Steven and discrimination against people with substance use disorders. It is not possible to know what was in the minds of individual staff when they made decisions about care However, the case does raise questions about practice in the Hospital and this report is suggesting a general review of practice with this client group in the ED setting and this issue of unconscious bias should be considered in that context.

8.7 Hospital Alcohol Care Teams

The Acute Hospital, similar to many Hospitals in England, has an Alcohol Liaison Service. This was operational at the time of Steven's final admissions and he was seen by this service in December 2020 and April 2021. However, there is no evidence that the Liaison Service was involved with Steven between September and November 2022. It is not clear why this did not happen and raises a question about whether Hospital staff are linking clients to this service.

9. The District Nursing Service

The comments about organisational abuse also focused on the response from the District Nursing services. In mid-October, a referral was made by the Alcohol and Drug Service to the District Nursing Service in order for Steven's staples to be removed in the community. However, this did not occur. There appears to be some debate and confusion as to why this did not occur. This includes questions about an incorrect address and who could request the Nurses to undertake the work. The former problem appears to relate to his earlier wrist fracture which was less crucial to his wellbeing.

The reality seems to be that he was offered three appointments at a clinic base and did not attend, in the same way that he did not engage with the Hospital to have them removed. The District Nursing Service made unsuccessful efforts to contact him via both the Pharmacy and the Alcohol and Drug Service. As a result, the staples remained in Steven's wound for a prolonged period, leading to an infection developing. It was then escalated to the GP for further action. A new referral was sent to the District Nursing Team by the Alcohol and Drug Service on 18 November 2022 and an appointment booked for 22 November. The District Nurses visited him on 22 November but he had already died.

Discussion at the Practitioners' Workshop confirmed that these staples needed to be removed and that non-removal posed a serious risk of sepsis and death. This, therefore, raises three questions:

- Should the response to the non-contact from a man with infected staples in his leg have been more assertive than simply handing it back to the GP?
- If there is clear need for someone to receive medical treatment, but they are

refusing, how proactive should services be in finding alternatives that are better suited to their needs?
- Would escalation to a multi-agency group have helped manage this situation?

As with the Hospital, this suggests the need for a review of local community health practice with complex client groups, in particular, how they are flagged for a more assertive or multi-agency response. These review processes could usefully be undertaken in combination.

10. Difficulty of Engagement – the need for a policy

Steven had a number of aspects to his presentation – his substance use disorder, possible mental health concerns, health problems and self-neglect. However, one issue underpins all of these issues – he is very difficult to engage with services. Throughout the notes there are examples of problems engaging him e.g.:

- The District Nurses cannot contact him to remove his staples.
- The Alcohol Service frequently lose contact with Steven.
- He does not engage with the Police over reports that he is being targeted by others.

Above all, although Steven consented to a degree of assistance (for example, allowing Housing Support Workers to contact his GP, collect his prescriptions etc), he consistently refused the medical attention he required in order to treat his serious wound infection. Steven would decline admission to Hospital when paramedics attended, or if he was taken to Hospital, he would discharge himself within hours.

This situation highlights the need for a specific published procedure to guide professionals on dealing with client non-engagement. To make that procedure useful it will need to provide guidance on:

- how to judge the level of risk or vulnerability that warrants ongoing, assertive action;
- how to practically intervene with hard to engage clients; and
- how to escalate these concerns and where they should be escalated to.

This process, whether single agency or multi-agency, would also benefit from guidance on what techniques work with hard to engage clients. This is an under-developed field. The SAR author looked for national guidance on this issue as part of the drafting of this report but could not find an overarching guidance document. Reports such as "The Keys to Engagement" (mental health)[4] and "The Blue Light Project" (alcohol misuse)[5] have addressed this issue with specific client groups but there is no single guidance document. Whether at a local or a national level, such guidance will be a vital support to those working with vulnerable and difficult to engage clients.

[4] https://www.centreformentalhealth.org.uk/sites/default/files/keys_to_engagement.pdf
[5] https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project

Steven is not unusual in presenting difficulties of engagement. The Manchester Safeguarding Partnership *Carers Thematic Learning Review 2021* identifies the same issue: *The challenges of supporting adults who do not consent to treatment or support and who are judged to have the capacity to make those decisions in an informed way…* It also recognises failures to escalate these individuals.

The same review goes on to comment on: *a sense that their persistent refusal of offers of care and support were perhaps too readily accepted, perceived and interpreted by practitioners as 'non-compliance' rather than as a form of self-neglect, which was a product of the adults' adverse life experiences, poor quality of life and very challenging day to day living*.

Another review from Manchester, the *Homelessness Thematic Review,* comments that: *When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; loss and trauma often lie behind refusals to engage. Contact should be maintained rather than the case closed, in an effort to build up trust and continuity.*

It was suggested in the Practitioners' Workshop that training around Alcohol Change UK's Blue Light manual which focuses on working with change resistant dependent drinkers would be helpful locally.[6]

11. Alcohol and drug use disorders

Steven had a substance use disorder which, undoubtedly, had a significant impact on his life and on the problems that led to his death. This section considers the specific responses to his alcohol and drug use.

11.1 Alcohol and drug screening and identification

At the very least, Steven's case is a reminder of the importance of robust alcohol and drug screening processes to ensure that substance-related risk is identified and highlighted by all the agencies that are working with an individual. In accordance with NICE Public Health Guidance 24, professionals working with the public need to be alert to the possibility of alcohol use disorders and should be routinely asking the AUDIT questions and using professional curiosity to explore this issue. Best practice would ensure that the AUDIT alcohol screening tool[7] is routinely being used by all relevant professionals, whether in Primary Care, Mental Health Services, Adult Social Care, Housing or any other adult service. The same guidance is applied by NICE to drug use. For drug users the best screening tool is ASSIST-Lite.

[6] For transparency purposes it should be noted that the author of this report is the co-author of the Blue Light project manual.

[7] Alcohol Use Disorders Identification Test (AUDIT) (auditscreen.org)

11.2 Community interventions

In October 2023, the Office for Health Improvement And Disparities published the *UK clinical guidelines for alcohol treatment.* These set out the standards that can be expected from Alcohol Treatment Services. Any assessment of the work undertaken by local Alcohol and Drug Services needs to be seen in the context of this guidance.

Steven was attending local Alcohol and Drug Services from November 2019 until his death. Prior to that he was a client of services in Leeds. Steven was prescribed Opiate Substitute Treatment (OST) and provided with support aimed at reducing his alcohol use.

The local services appear to have worked very hard to engage Steven and were a significant source of support to him and advocacy on his behalf. They raised the section 44 request for a SAR and have been robust in challenging unconscious bias against people like Steven. His OST was well managed and maintained throughout the period and there was good liaison with the Pharmacy and the Hospital over aspects of his script.

The response to his drinking was more challenging as Steven was often ambivalent about, or non-compliant with, these interventions. It is positive to note that the Alcohol and Drug Service kept his case open and actively worked to keep him engaged despite his apparent poor compliance.

However, it also raises questions about what else might be required to meet Steven's needs. A range of evidence now identifies "what works" with difficult to engage chronic dependent drinkers. This is most clearly summarised in Alcohol Change UK's Blue Light project manual.[8] However, the Clinical Guidelines, the Carol SAR from Teesside and the Alan SAR from Sunderland provide examples of other endorsements of this approach.

At its core is:

- A care package centred on intensive assertive outreach.
- A co-ordinated multi-agency management approach to guide and support the work.
- The willingness to be consistent and persistent and to allocate time to the task

The Alcohol and Drug Service certainly met the third item in this list. Multi-agency management is dealt with elsewhere (section 13). This section focuses on assertive outreach.

Steven could well have benefited from an assertive outreach approach which would have attempted to build a relationship with him in order to understand what lay behind his challenging behaviour. Is it cognitive impairment? Is it shame about the way he is now living? Is it fear that intervention might interrupt his supply of alcohol or cigarettes? Is it concern that he may lose his independence?

[8] Again it needs to be noted that the author of this review is a co-author of the Blue Light manual.

An assertive outreach approach is built on the recognition that, with complex individuals such as Steven, agencies are going to need to sustain the relationship rather than expecting him to be able to do that. This will require an approach that is:

- Assertive – using home visits
- Focused on building a relationship
- Flexible – client focused – looking at what the client wants
- Holistic – looking at the whole person
- Coordinated – linking with other agencies
- Persistent and consistent.

Once professionals have a better understanding of what is behind this pattern of non-engagement, they can begin to think about ways in which his needs can be better addressed. This might have ranged from using practical approaches such as putting up a reminder notice board with appointment times and pictures of workers who were going to visit through to an outreach worker being present at appointments with him, the use of motivational interviewing and on to a better understanding of how the Mental Capacity Act could be used in his case.

Steven is likely to have benefited from the availability of specialist assertive outreach staff who could have worked with him. This was not available during the period under review. However, it is understood that assertive outreach capacity is now being developed. The question, therefore, is whether this will be adequate or if more input is required to meet local need?

11.3 Detoxification and residential rehabilitation

It was generally agreed at the Practitioners' Workshop that the best pathway for Steven would have been detoxification and residential rehabilitation. This would have enabled:

- A time away from his home situation in a protected environment;
- A chance to properly assess his mental health and consider any possible cognitive impairment; and
- A chance to address the substance use disorders and develop an appropriate care plan.

This would not have been an easy answer to his problems. Dame Carol Black's national *Review of drugs part two: prevention, treatment, and recovery* states that*: Local commissioning of inpatient detoxification and residential rehabilitation has decreased substantially in recent years, despite evidence of their effectiveness and importance for people with particularly complex needs.* It is probable that there would have been problems finding an appropriate placement. However, the review agrees that, given the range of possible care packages, a detoxification followed by some form of "dry" residential rehabilitation would have been the best option.

Access to residential rehabilitation may not have been a simple route to the resolution of Steven's problems. However, it is important that:

- persistent efforts should have been made to "sell" this approach to him by all professionals;
- funding should have been available via commissioners for this approach without unreasonable barriers if he expressed interest in this option; and
- commissioners should support and encourage the development of residential facilities that will work with more complex alcohol use disorders including those with possible cognitive impairment.

To move into rehabilitation Steven would have required a detoxification. This would probably have needed to have been an inpatient detoxification, both because he was assessed as severely dependent (June 2021) and because he was also dependent on opiates (the Clinical Guidelines state that these are both an indicator of the need for inpatient detoxification).

At points Steven was requesting a detoxification himself (e.g. 2/6/20, 2/6/21) and a process that was moving towards this goal was in place from mid-2020. This never came to fruition. In part this is because of his patterns of chaotic behaviour; but systems may also have played a part.

The Clinical Guidelines state that *Every local treatment system should have a pathway so that people with the highest levels of need can access specialist inpatient medically assisted withdrawal. People should be able to access it easily and without any unnecessary delays.* It is not clear that the approach taken with Steven achieved this standard. For example:

- In March 2021, *It was discussed that for Steven to have a referral submitted for in-patient detox, he would need to work on reducing his alcohol daily intake to approximately 25 units.* This would be a high bar for someone like Steven and raises the question of whether this represents accessing detoxification "easily".
- In mid-June 21 he initiated a detoxification process by attending his GP to have blood tests taken. This process had not been completed by August and in September he was being asked to repeat the blood tests.
- NICE guidance CG100 suggests that a poor housing situation is an indicator of a need for inpatient detoxification, yet this seems to be at variance with the approach used in Wakefield which required people to have stable accommodation before accessing a detoxification and thereby residential rehabilitation.

There may have been very good day to day reasons why Steven did not progress to an inpatient detoxification / residential rehabilitation pathway. However, Steven's situation does raise questions about whether the local alcohol detoxification pathway needs to be reviewed against the standards set out in the Clinical Guidelines.

12. Inter-agency communication and multi-agency management

Inter-agency communication and multi-agency working was clearly identified as an important theme in the Practitioners' Workshop. This theme was also raised in the various reports on his care. For example, the SAR referral and other documents for the Panel identified problems in this area:

- Difficulties in communication between the Alcohol and Drug Service and healthcare providers (GP practice, Hospital, District Nursing) – the Alcohol and Drug Service staff felt their first-hand information about Steven and their subsequent recommendations/requests were not always heard by health professionals. In particular, they stated that better links with the Acute Trust were needed to ensure their service users can access acute healthcare when they need it.
- The Alcohol and Drug Service cite difficulties in communicating with the Police regarding the most appropriate risk prioritisation/categorisation of Steven as a missing person.
- Steven's Housing Provider states that they requested updates about his admission/discharge from Hospital on 21 November 2022, but only found out he had discharged himself the following day from the District Nurse, this led to a delay in trying to ensure Steven's safety and report him as missing to the Police.
- The SAR Panel noted that: "*People had information regarding Steven but was this shared or escalated, were his vulnerabilities flagged anywhere…communication between agencies and escalation of input when he deteriorated could have been better"*.
- In the Practitioners' Workshop it was commented that a lot of professionals were involved with Steven but they were not all pulling together and, therefore, services like the Emergency Department did not have a full picture of his needs.

Steven would have benefited from regular multi-agency discussion. This would have supported clear and positive inter-agency liaison and multi-agency working. This could have been addressed in a number of ways: as part of a safeguarding process; by having a clear policy on dealing with difficult to engage clients; by having a specific policy on calling multi-agency meetings; through referral to an existing multi-agency group; or through individual initiative by another professional. The Acute Trust has a High Intensity Users Group but Steven does not seem to have been referred to this group.

Whichever way this was approached, Steven would have benefited from a group that could have stepped back from the day to day interventions and seen the overall picture of the problems he presented and considered ways in which these could have been better addressed.

The Practitioners' Workshop felt that there was a need for a local multi-agency group to which people like Steven could be escalated. This group would need to embrace the range of agencies that could have worked with him across Health Services, Alcohol and Drug Services, Adult Social Care, Housing and Homelessness, Police and other Emergency

Services. It was acknowledged that there is ongoing work to develop such a forum in the area.

13. Safeguarding and other Adult Social Care interventions

In the last year of his life, Steven may have been an adult with care and support needs and the Care Act could have provided a framework for addressing the challenges he posed, as well as protecting him from further harm. However only one safeguarding concern was raised about him during the review period. This was from the Ambulance Service and was submitted the day before he died. It cited concerns about self-neglect and his living conditions. The concern stated that Steven had a wound from September, but was refusing treatment. The referral was closed by Social Care Direct because Steven had "no eligible Care Act needs".

It has been acknowledged by Adult Social Care that this decision was flawed. An adult does not need to have eligible needs to initiate the section 42 duty to safeguard, and Steven's care and support needs were last assessed in May 2021, so there was no current awareness of his eligibility.

Agencies in the Practitioners' Workshop acknowledged that there were also missed opportunities to raise safeguarding concerns.

Prior to November 2022, Steven was not identified as requiring a safeguarding referral. However, the information provided to the review indicates that Steven had required support relating to self-care for some time. His GP practice indicates that from 2019-21, his sister acted as his representative: organising all his appointments and treatment.

In June 2022, he was 'threatened' by one of his housemates. The Alcohol and Drug Service consider this to have been a missed safeguarding opportunity. Following his leg operation in September 2022, Steven did not access the care he needed for the staples in his wound and subsequent infection. His Housing Provider reports that he was unable to dress/undress without support and was soiling himself without recognising this was happening. He would forget to take his antibiotics without prompts from staff, and went several days without taking these in the days prior to his death. However, no safeguarding concern was submitted until immediately before his death.

He had also had poor engagement with both the Hospital and community-based health care and faced potentially life-threatening issues with the staples in his leg. Again this had not resulted in consideration of the need for a safeguarding concern.

If a safeguarding referral had been submitted and accepted in September 2022, that could have led to a multi-agency meeting which could have provided a more coordinated and

assertive response to his care. That opportunity was missed by the agencies involved with him.

Ultimately, only the Ambulance Service submitted a safeguarding concern and although it was promptly, and probably wrongly, closed it would have been too late to make any difference to the course of Steven's deterioration.

It was also agreed at the Practitioners' workshop that Steven could have benefited from a further assessment of his care and support needs under section 9 of the Care Act.

14. Using the Mental Capacity Act and beyond

14.1 General

Mental capacity has already been discussed above in the context of the last days of his life. In particular, the report highlighted the importance of considering executive capacity with dependent drinkers and drug users.

The notes provided to the review indicate that Steven was consistently regarded as having mental capacity to take decisions for himself. In retrospect, it is hard to judge whether Steven should have been viewed as lacking mental capacity to take key decisions on other occasions. What can be said is that the lack of a clear multi-agency framework around Steven's care would have hindered the use of the Mental Capacity Act. Within a multi-agency meeting, professionals could have considered his mental capacity from a number of angles and have professionally challenged others over situations in which they felt that the approach was inappropriate.

Ultimately, even if it is argued that Steven is capacitated, this should not be the end of his care. The report of *The 2013 Mental Capacity Act 2005: Post-Legislative Scrutiny*, criticises the use of the Act in this way: *The presumption of capacity…is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm.*[9] The MCA Code of Practice repeatedly highlights the need to assist a capacitous person who is *"repeatedly makes repeated unwise decisions"*[10] or to undertake *further investigation in such circumstances.*[11]

14.2 Beyond the Mental Capacity Act

It might also have been possible to move beyond the Mental Capacity Act and to build a case for action on the need to preserve his Article 2 rights under the Human Rights Act – the right to life? (Or indeed Article 3 – freedom from degrading treatment). This is not a widely used approach in the substance misuse field, but, in Manchester, the Substance Misuse Social

[9] Mental Capacity Act 2005: Post-Legislative Scrutiny 2013 105
[10] Mental Capacity Act 2005: *Code of Practice 1.2*
[11] Mental Capacity Act 2005: *Code of Practice 2.11*

Work Team is using the Human Rights Act to drive intervention with individuals where other frameworks have not proven viable. This is a route that may have been worth consideration by, for example, the Alcohol and Drug Service in Steven's case.

14.3 The adequacy of existing legal frameworks

Steven highlights problems with the existing legal frameworks for managing people with chronic alcohol or drug use disorders. Both the Care Act and the Mental Capacity Act highlight the importance of individuals having the right to self-determine, e.g.:

- The importance of beginning with the assumption that the individual is best-placed to judge the individual's well-being; (Care Act)
- The importance of the individual participating as fully as possible in decisions (Care Act)
- A person is not to be treated as unable to make a decision merely because she makes an unwise decision. (MCA)

However, this prioritisation is very challenging to negotiate when someone's alcohol or drug use and related choices constantly place them at very serious risk of harm; and, moreover, when they appear to be repeatedly choosing to return to that lifestyle (and repeatedly articulating that choice).

The challenges posed by this situation are even greater when one turns to the guidance on the legislation:

- The Code of Practice on the Mental Capacity Act mentions alcohol and drugs just three times.
- The Guidance on the Care Act mentions alcohol and drugs just twice.

Practitioners are working in the absence of any clear statutory guidance on how to negotiate the type of challenges posed by Steven. This is not an isolated issue, for example, 25% of SARs feature people with significant alcohol use disorders.[12] This does raise the question of whether England needs a new legislative framework for managing chronic dependent drinkers and drug users?

Other Westernised countries do have legislation which is specific to this client group and allows the compelled, protective, detention of dependent drinkers like Steven. In some jurisdictions this is called "civil commitment" (e.g. USA).[13] [14] [15] Indeed Article 5 of the European Convention on Human Rights specifically recognises this possibility.[16] Such

[12] Preston-Shoot M. et al. - National SAR Analysis: April 2017-March 2019 – LGA / ADSS (2020)
[13] http://www.emcdda.europa.eu/attachements.cfm/att_142550_EN_SE-NR2010.pdf
[14] http://www.legislation.govt.nz/act/public/2017/0004/latest/DLM6609057.html?search=ts_act%40bill%40regulation%40deemedreg_substance+addiction_resel_25_a&p=1
[15] http://www.namsdl.org/IssuesandEvents/NEW%20Involuntary%20Commitment%20for%20Individuals%20with%20a%20Substance%20Use%20Disorder%20or%20Alcoholism%20August%202016%2009092016.pdf
[16] Article 5 of the *European Convention on Human Rights* (the *Right to liberty and security)* states that:

legislation might have provided a framework within which Steven's needs could have been managed.

Three options exist for addressing this gap:

- Revised guidance / code of practice or specific guidance as per the CQC guidance on the Mental Health Act & Eating Disorders
- Revisions to the existing legislation
- New legislation as per other countries.

In the short term, it is most realistic to look for a change to the guidance on the legislation. In particular, clarification about how the Mental Capacity Act and the Care Act should be applied to this client group including case study examples. This would cover issues such as "executive capacity" or how the self-neglect provisions of the Care Act apply to dependent drinkers.

The Safeguarding Adults Board may want to consider pressing national government, at the least, for better guidance on how to use the existing legislation most effectively with this client group.

15. Covid 19

Much of the period under review was during the Covid-19 restrictions. This will have impacted on Steven's care. It would also have been harder to have pursued an assertive outreach or other community approach in this period. This needs to be acknowledged when considering Steven's care. However, generally services seem to have managed Steven appropriately in this difficult period. The Alcohol and Drug Service continued to see him face to face throughout the restrictions.

However, the last and crucial year of his life was lived during a period in which the Covid restrictions had been eased or removed completely. Therefore, it is likely that the Covid restrictions had some impact on his care; however, it is certainly not possible to draw a direct line between the Covid restrictions and Steven's death. Therefore, no comments have been made on this.

Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;

16. Benefits back payments

From March 2020 until April 2022, Steven lived in accommodation provided by a local homelessness charity. However, he lost his place there due to complaints from fellow residents (including threatening a fellow housemate) and became homeless again. The Manager of the unit blamed a large back payment of benefits (PIP) which led to "hangers on" gathering around him for his money and causing his commitment to treatment to decline.

This is a situation that is seen repeatedly in SARs and in other care situations. Large benefits back payments destabilise individuals and lay them open to abuse. This is not an easy situation to address. For many the real problem will appear to be the previous lack of payment rather than the large back payment. People also have the right to their money. However, such large lump sums can be destabilising for people with substance use disorders.

As part of this process the Department for Work and Pensions were approached for input. They provided the following information.

DWP has introduced high value payment guidance in 2021 to support vulnerable customers when making a large payment of arrears. If a customer does not have a Power of Attorney, appointee or representative and the arrears are over £5000 then we must make a courtesy call to the claimant to advise them about the payment and to ensure they can manage the money themselves. We would during this call give the customer clear payment options:
1. Lump Sum
2. Payment to a 3rd party
3. Staggered payment
4. Split payment

If the amount is £2000 or above, DWP policy is that we would check Benefit systems for key indicators of potential vulnerability, however for PIP regardless of the amount if we have advanced customer support concerns we have guidance/steps to follow in order to consider if the customer requires us to make a change to how they are paid.

In Steven's case it was reported that the payment was below the £5000 threshold and they did not identify the customer as vulnerable at the time the arrears were paid. *The customer was seen as living in 24/7 supported accommodation and had the full support of a Support Worker (who supported him to make the claim to PIP).*

This is a situation which may require both local and national discussions with the Department for Work and Pensions to determine if further changes are required to this approach.

17. Smoking

Steven appears to have stopped smoking at the very end of his life, however, he had been a long-term smoker and this may have contributed to, or worsened, some of his physical health problems. He died as a result of respiratory suppression and smoking could have contributed to poor lung function. Smoking contributes not only to the worsening of lung disease but also liver disease and raises the risk of fire hazards. Reducing smoking among people with mental health problems is an Office for Health Improvement and Disparities priority. There has also been a governmental focus on smoking among people with substance use disorders. Therefore, it is important that professionals recognise the need to address this issue with people with substance misuse disorders. There needs to be a focus on addressing smoking in this client group and Alcohol and Drug Services should recognise the importance of smoking cessation with their clients.

18. Key Learning Points

Steven's life and early death highlight themes related to the management of substance use disorders but also to wider themes associated with complex individuals. With regard to substance use, these themes are particularly important because Wakefield has an above average drug and alcohol death rate. Therefore, there is an urgency about tackling these issues.

The key focus is Steven's health crisis in the last months of his life: in particular, his engagement with the Hospital. In that period Steven did not engage with the Hospital care he needed to remove staples in a leg wound and ultimately, in the hours prior to his death, he left the Hospital with treatment incomplete. This phase raises questions about:

- The flagging of clients who are at serious health risk but are difficult to engage in the Emergency Department
- The management of people with dependencies who are attending the Emergency Department
- The use of the Mental Capacity Act with this client group
- Information-sharing after discharge
- The attitudes of staff to this client group.

Steven had had a series of recent failed engagements with Acute Trust services both in Hospital and in the community. The Trust also held information on the seriousness of his health situation, in particular the risk of sepsis. The question is: were people involved in Steven's care aware of, and did they use, this information as part of their decision-making? If not, does that highlight a process issue that needs to be addressed? Does a client in Steven's situation require some kind of flagging to raise awareness of the seriousness of his condition and the challenges he will pose? It was ultimately very predictable that Steven would leave.

This incident suggests that a review should be undertaken of how the Emergency Department can manage vulnerable and difficult to engage people in the future. This should address the questions outlined above including how information about vulnerable individuals is used within the Hospital or Trust e.g. were staff aware of his risk of sepsis and his previous history of disengagement? Would referral to the High Intensity User Group have assisted?

People with dependencies who are attending the Emergency Department may be at risk of physical withdrawals. These can certainly be very serious and potentially life threatening (mainly in the case of alcohol). Therefore, it is important to ask how their withdrawal symptoms will be managed so that they can engage with care without bringing alcohol or drugs into the Hospital. This appears to have been a problem for Steven in attending the Emergency Department.

This is a challenge that will affect every Acute Hospital in the country. However, there is no national guidance on this and therefore, it would be useful if the Acute Trust developed a policy on this in partnership with the local Alcohol and Drug Services. This could usefully draw on experience in other areas of the country.

At the very end of his life, Steven left Hospital with treatment incomplete. This raises questions about the use of the Mental Capacity Act with this client group. It is not clear whether a mental capacity decision was taken that he could leave the Hospital or whether he simply left unobserved. However, some consideration of his capacity was required. In part this is a process issue to ensure that, once in the Hospital, staff are aware of the need to consider his capacity if he appears to want to leave.

In assessing capacity with dependent drinkers like Steven it is important to consider executive function. Repeated refusals of care should raise questions about the ability to execute decisions. The draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function as well as considering repeated failed decisions when assessing capacity.

Steven's engagement with the Emergency Department also raised questions about information-sharing when he left. At the very end of his life it is a moot point whether raising him as a missing person with the Police would have been beneficial. However, it is noticeable that when he left Hospital in September 2022, there was no communication with the Alcohol and Drug Service despite their input to the Hospital on his prescribing regime. This should also form part of the review of practice in the Emergency Department with such clients.

The original SAR referral raised questions about whether negative attitudes to people with alcohol problems contributed to the problems that Steven experienced. It is very hard to draw a line between what ultimately happened to Steven and discrimination against substance misusers. It is not possible to know what was in the minds of individual staff when

they made decisions about care However, this report is recommending a general review of practice with this client group in the Hospital setting and this issue of unconscious bias should be considered carefully in that context.

The original SAR referral categorised Steven's management in the Hospital as "Organisational Abuse". This is a nebulous term and this Review has not commented on it specifically. It is probably more helpful to focus on the points above and these already suggest the need for a more general review of how the Hospital responds to people with Alcohol and Drug Use Disorders.

In raising the issue of "Organisational Abuse", the SAR referral also raised the approach from the District Nursing Service. The Service were unable to remove the staples from his leg because he failed to attend clinic appointments and he was handed back to the GP. There is no specific evidence that attitudes to alcohol and drug use disorders impacted on this. However, again it does suggest the need for a process review in the District Nursing Service to understand whether the approach taken to the removal of Steven's staples was assertive enough given his vulnerability and the level of health risk. This could form part of, or run alongside, the review of practice in the ED that was suggested above.

Beyond the events of the last two to three months of his life, Steven was both dependent on alcohol and had a pattern of heroin use. At the very least, Steven's care highlights the importance of standardised screening tools. In particular, following NICE Public Health Guidance 24, the AUDIT alcohol screening tool should be widely used by all frontline professionals to provide a consistent means of communicating information about alcohol-related harm. NICE makes the same recommendation about screening for drug use using Assist-Lite.

In general, Steven had very good care from the local Alcohol and Drug Service. One question about the community pathway is whether there needs to be investment in the development of assertive outreach capacity with this client group. This was certainly a gap in the care of Steven although the service did make robust efforts to continue working with him. It is understood that work is under way to address this gap.

The more specific concern is the pathway into detoxification and residential rehabilitation. Steven appears to have been on this pathway for over two years without any positive outcome. In part this was because of problems engaging Steven but aspects of the pathway seem to be at variance with the principles and practice set out in the new Clinical Guidelines. It is suggested that the local pathway into detoxification and rehabilitation is reviewed against those Guidelines.

Beyond substance use, Steven's care also raises more general questions about various aspects of his care.

A key feature of Steven's presentation is that he was difficult to engage in services. Professionals' responses will be strengthened by the development of a local policy or procedure which guides them on how to work with these difficult to engage individuals and includes such issues as the level of risk that requires a more assertive approach and identifies the need to escalate the more vulnerable, hard to engage clients, to a local multi-agency forum for joint management. This would be further improved by having services, like assertive outreach (mentioned above) that are able to reach out and engage clients who are reluctant to engage with mainstream services.

For these individuals a multi-agency perspective is essential. The absence of multi-agency management was a particular feature of Steven's care. Irrespective of the development of an engagement policy, it is important that there is an identified pathway into multi-agency management for complex clients locally.

Only one safeguarding concern was raised about Steven during the review period. This was from the Ambulance Service and was submitted the day before he died. It cited concerns about self-neglect and his living conditions. The concern stated that Steven had a wound from September, but was refusing treatment. The referral was closed by Social Care Direct because Steven had "no eligible Care Act needs". It has been acknowledged by Adult Social Care that this decision was flawed, especially as Steven's care and support needs were last assessed in May 2021, so there was no current awareness of his eligibility.

Agencies in the Practitioners' Workshop acknowledged that there were likely to have been missed opportunities to raise safeguarding concerns at other points. This is especially the case in the last months when his health was seriously deteriorating and he was not engaging with care. If a safeguarding referral had been submitted and accepted in September 2022, that could have led to a multi-agency meeting and a more coordinated and assertive response to his care. That opportunity was missed by the agencies involved with him.

It was also agreed at the Practitioners' Workshop that Steven could have benefited from a further assessment of his care and support needs under section 9 of the Care Act.

This does suggest the need to remind all staff of the importance of both raising safeguarding referrals and seeking section 9 assessments generally and of a need to highlight their importance with this group of people who are both self-neglecting and dependent on alcohol or drugs.

This section has already commented on the use of the Mental Capacity Act in the Emergency Department prior to his death. More generally cases like Steven's should also remind practitioners of the importance of using the Human Rights Act (e.g. article 2 right to life) to drive interventions when other approaches have not worked. It also highlights the limitations of the existing legislative framework which is not well-designed to meet the needs of this group. Therefore, the Safeguarding Adults Board may want to consider

pressing national government for better guidance on how to use the existing legislation most effectively with this client group.

Steven was a regular smoker and respiratory problems contributed to his death. This is a sub-theme in this SAR but it is reminder that agencies should be considering the impact of smoking from two perspectives:

- the heightened risk of accidental fire and fire death in people with alcohol and drug problems who are also smoking; and
- the prevalence of smoking and its specific impact on the health of people with alcohol and drug problems.

In early 2022, Steven was in receipt of a large benefits back payments. This appears to have destabilised his engagement with treatment and laid him open to abuse. This is not an easy situation to address. For many the real problem will appear to be the previous lack of payment rather than the large back payment. People also have the right to their money. The Department for Work and Pensions have introduced a policy on this; however, this only relates to payment over £5000. Steven's payment was below this threshold and, therefore, this is a situation which may require further local and national discussions with the Department for Work and Pensions to determine if any more changes are required.

19. Good practice

Many agencies made efforts to help Steven. Most professionals appear to have worked appropriately with him within the framework of their individual disciplines. In particular, much of the work undertaken was during the Covid-19 restrictions and it is clear that agencies continued to work and maintain services during that difficult period.

However, specific points of good practice did emerge:

- The Alcohol and Drug Service and his final Housing Provider made considerable efforts to get Steven the help he needed.
- A significant amount of positive care was provided to Steven by the Alcohol and Drug Service. There was a persistency and thoroughness in terms of attempting to keep the client engaged in his treatment despite the fact that his engagement was poor. Risks were identified and attempts made to mitigate against these were evident.
- At the time of Steven's death, the Alcohol and Drug Service had a Social Worker seconded from Wakefield Council. This is a model of good practice in the national context.
- Community Nursing and the Pharmacists linked together well regarding his medication. There were also good links between the Alcohol and Drug Service and the Pharmacy.

- The Pharmacy offered to deliver Steven's medications when he was struggling with his leg fracture.
- The GP Practice put him on a vulnerable patient list to ensure he received his medication even if he didn't seek a further supply.
- Steven was provided with a safe storage lock box and a naloxone kit to mitigate risks with his prescribed opiate use.

It should also be noted that a number of agencies constructively identified areas for individual agency action in their SAR submissions. This includes the Ambulance Service, Adult Social Care and the Acute Hospital and Community Trust.

20. Recommendations

Recommendation 1

Wakefield SAB should reassure themselves that the local Public Health Team are working to ensure that all frontline services are aware of, and are able to use, robust alcohol and drug screening tools such as the AUDIT tool or Assist-Lite to identify and record the level of substance related risk for clients.

Recommendation 2

Wakefield SAB should ask the local Commissioners of Alcohol and Drug Services to undertake a review of the pathway into detoxification and rehabilitation to ensure that it meets the standards set in the Clinical Guidelines.

Recommendation 3

Wakefield SAB should work with relevant partner agencies to develop local guidance on managing dependent drinkers and drug users who risk withdrawals while awaiting medical care in the Emergency Department. This may require, and benefit from, work at a regional or national level.

Recommendation 4

Wakefield SAB should ask the Acute Trust to undertake, and report on, a review of various process themes in the healthcare system:

- The use of information about disengagement patterns and vulnerability as drivers of intervention in the Emergency Department with complex clients
- Whether such clients are being appropriately escalated in to the High Intensity User Group
- Information-sharing about people who disengage from healthcare who are suffering from a serious health condition
- The follow-up of non-engaging clients with serious health concerns by District Nursing.

Recommendation 5

Wakefield SAB should undertake work to ensure that unconscious bias against people with alcohol and drug use disorders is not influencing the way health and other services are provided. This work could include training or professional development work around:

- Understanding withdrawals and detoxification from alcohol and drugs.
- Working with change resistant dependent drinkers as per Alcohol Change UK's Blue Light approach.
- Professional curiosity to ensure practitioners see a full picture of the needs of individuals with alcohol and drug use disorders.

Recommendation 6

Wakefield SAB should lead the development of local procedures that guide professionals on how to respond to vulnerable or high-risk individuals whom agencies find difficult to engage. The SAB should ensure that those procedures include the option of assertive outreach and the need to escalate the more vulnerable, hard to engage clients, to a local multi-agency risk management forum for joint management. This can build on current work to develop such a forum in the area. The SAB should ensure that the importance of escalating concerns about more vulnerable clients is cascaded as widely as possible through their own and partner agency communication systems.

Recommendation 7

Wakefield SAB should ensure that there is ongoing training and messaging about the need to raise safeguarding concerns about vulnerable individuals and those with alcohol and drug use disorders in particular.

Recommendation 8

Wakefield SAB should ensure that guidance or protocols are available to support professionals to consider the use of the Mental Capacity Act in the context of clients that agencies find difficult to engage generally and people with alcohol and drug use disorders specifically. This should include reminders about the importance of considering executive capacity.

Recommendation 9

Wakefield SAB should ensure that organisations who constructively identified a need for individual agency action in their SAR submissions are addressing those specific issues. This includes the Ambulance Service, Adult Social Care and the Acute Hospital and Community Trust. The individual areas identified should be included in the SAB action plan.

Recommendation 10

Wakefield SAB, in conjunction with those who commission and plan the development of alcohol treatment services, may wish to consider lobbying national government for either improved guidance on using the Care Act, Mental Capacity Act and the Mental Health Act with this complex client group; or new legislation to better meet their needs.

Appendix 1 Terms of reference

Key themes of the review are set out below and form the key lines of enquiry:

Accessing Steven's voice: (a) When, and in what way, were Steven's wishes and feelings ascertained and considered?
(b) How was Steven supported to make decisions for himself?
(c)Were there concerns about Steven's decision-making capacity?

Self-neglect: Was there evidence of Steven lacking self-care or lacking care of the home environment to the extent that it endangered his safety and wellbeing? Did agencies respond appropriately to these concerns?

Risk: Was any risk associated with Steven identified and appropriately addressed?

Organisational abuse: Did Steven and those supporting him have appropriate access to services to meet his health needs, especially when his health significantly deteriorated?

Substance misuse: What challenges and barriers exist for people experiencing substance/alcohol use disorders when accessing health and social care services in Wakefield? In particular, please consider the potential role of unconscious bias and also comment on whether any reasonable adjustments are made for people experiencing substance/alcohol disorders.

Clients who are difficult to engage: are there procedures and pathways for the management of individuals who are difficult to engage in services?

Joint working concerns: Was information sharing and communication between agencies and services appropriate and timely? In the final two weeks of Steven's life, did agencies and services respond appropriately to escalating concerns about his deteriorating health?

Safeguarding: Was safeguarding considered at any stage, were there grounds to raise a safeguarding concern at any stage, and might this have led to a change in practice?

Mental capacity: Was the Mental Capacity Act 2005 appropriately considered and implemented in practice? Was Steven's voice actively listened to in any mental capacity considerations?

Systemic issues: Did any systemic issues impact on Steven's care/ service delivery, including, for example, agency resource/ capacity issues, austerity, the COVID

pandemic, workforce knowledge and training in relation to supporting people with substance/alcohol use disorder?

Good practice: Was there any good or notable practice with Steven that should be flagged?