**‘William’ Safeguarding Adults Review (SAR):**

**Systems Findings Report**

A review commissioned by East Riding Safeguarding Adults Board (ERSAB)

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**William**

William was sixty-three years old when he died in September 2022, and as a person he was described by his close friend as cheeky, that he loved comedy and had a real skill for imitating others for comedy value. William lived alone and had few friends, but he enjoyed spending time with the people closest to him and he enjoyed being in the garden in the sunshine.

William was deaf from birth, and identified as Deaf meaning his first language was British Sign Language (BSL) with some sight problems too. During his working years, William taught level six BSL, and he was described as being very creative.

William was described as *a bit of a character* and was known to be stubborn at times, he was observed to misinterpret others sometimes particularly those who used English as a first language. At these times William was described as being confrontational and as a result this impacted on his relationships and increased his social isolation.

William’s close friend said that he had drunk alcohol for as long as she could remember although she noticed in the last year of his life he had drunk to such a level that it changed his personality. William’s close friend said that she thought William drank alcohol to a harmful level because he was lonely, and she tried to get help for him but said she did not get a response.

William reported that he drank alcohol to a harmful level for over thirty years, and he would often report to professionals that this was a behaviour normalised within his family. William’s harmful drinking appeared to increase around the time of the Covid-19 pandemic, and during this time he came to the attention of health and social care services because he was developing alcohol related physical health problems.

Around June 2022, it appears that William’s mental and physical health was significantly deteriorating as a result of his chronic drinking and his long term BSL interpreter and his close friend started to raise concerns around the extent of William’s self-neglect.

Between July 2022 to William’s death in September 2022, there were six separate concerns raised with East Riding of Yorkshire Council (ERYC), and one of them was identified as a formal safeguarding concern. These concerns were raised by William’s long term BSL interpreter, his brother, his close friend, and members of the public and each concern highlighted risks associated with his harmful drinking including being observed to have fallen and a previous accidental fire in his house, and significant concerns about self-neglect. Around this time, William also stopped having contact with his family and responding to his close friend.

Sadly, William was found deceased in his home by a visiting tradesperson and his cause of death was confirmed as intra-cranial haemorrhage (bleeding inside of the skull) due to fall, and it was thought William had been deceased twelve to twenty-four hours before being found.

On behalf of ERSAB and its partners, I wish to offer our sincere condolences to those who knew William.

**Methodology**

Section 44 of the Care Act (2014) requires that a SAR is undertaken where an adult with care and support needs has died or suffered harm as a result of abuse or neglect (whether known or suspected), and there is a concern that agencies could have worked together more effectively to safeguard the adult.

The ERSAB agreed that Williams’s case met the criteria for a statutory SAR because he was an adult with care and support needs and there were early concerns that he presented with self-neglect with potential lessons to learn. The time period examined for Williams’s review was between 2017 to his death in July 2022.

A system findings methodology was utilised for William’s review, which was influenced (but not used strictly) by the SAR in Rapid Time process. A system findings methodology focuses on the ‘system findings’ relating to any social or organisational factors that influenced the events and circumstances of the case, with the overall objective of identifying higher system learning.

The methodology adopted a flexible and bespoke approach as William’s case progressed and the methodology used was outlined as:

1. Author combined agency timelines and developed objectives of SAR (Terms of Reference)
2. First panel meeting held to agree objectives and themes
3. Author completed desktop thematic review
4. Author completed one to one meetings with individual practitioners, and William’s close friend
5. System findings draft report shared with partners
6. Structured multi-agency meeting to finalise the report and the findings
7. System findings report published

The objective of this flexible methodology was to identify the higher systems learning in William’s case at a quicker rate and as a pragmatic approach to the practitioner’s and agency’s resources and time.

The contribution of William’s close friend was crucial in providing us with his human story and on behalf of the ERSAB and their partners we would like to thank her for helping us to understand who William was as a person.

This SAR was chaired and authored by Lorna Warriner who is an independent Registered Mental Health Nurse (RMN) and who had no previous involvement in William’s case.

**System findings**

System findings are the underlying issues that influence practice and are focused on the systemic issues rather than the detailed specifics of William’s case, or the ‘one-off’ findings. Each finding described below aims to describe the barriers and enablers in the wider system and how that influenced the events and circumstances in William’s case.

This approach requires us to think more widely and beyond what happened to William and the local organisational factors that influenced the circumstances and events, but also the wider system issues to influence national change and bring practical value.

This document provides the system findings, and a short number of questions are posed to the ERSAB and their partners who can decide on the appropriate response and actions in response to the learning in this SAR. This approach has been adopted due to the acknowledgement that the ERSAB and their partners are closer to and know their services better than a SAR author.

**FINDING ONE:**

**William’s chronic harmful drinking was not seen within the same context as self-neglect.**

There is not a single definition of what self-neglect is, but the Social Care Institute for Excellence (SCIE) describes self-neglect as an *extreme lack of self-care, which…..may be a result of issues such as addictions[[1]](#footnote-1).*

A person can be defined as self-neglecting when they present with one or more of the following:

* Lack of self-care, which can include hygiene, nutrition, hydration or health to an extent that may endanger safety or wellbeing
* Lack of environment care, that may lead to domestic squalor or elevated levels of risk
* Refusal of assistance that might mitigate the risk of harm, this could include refusal of services at home or health assessments that could potentially improve self-care

The agencies that came into contact with William did not properly identify and understand that he was self-neglecting within the same context as his chronic harmful drinking, as defined in the Care Act (2014). The Care Act (2014) also identifies that people who drink to a harmful level may fall within its remit because they could be eligible for care and support.

William’s long-term drinking was viewed largely as a lifestyle choice which appeared to be supported by agencies stating that he had mental capacity in accordance with the Mental Capacity Act (MCA) (2005) to decide not to engage in services.

It is important to note that William’s mental capacity was not formally assessed and there is no requirement for practitioners to do so if they do not hold a reasonable belief that William may have lacked capacity. However, it was unhelpful to see his chronic drinking (and thus self-neglect) as a lifestyle choice rather than a consequence of an underlying unmet need that would have required a safeguarding framework.

It could be argued that when William was advised not to reduce his alcohol intake too quickly due to a potential risk of withdrawal symptoms that could have been detrimental to his health, he no longer had the same choice over his decision to drink alcohol.

William needed services to work with him in a consistent but flexible way that attempted to ,understand and help him with his underlying reasons for his chronic drinking. According to Braye et al (2015[[2]](#footnote-2)), the best practice approach for working with those who are self-neglecting is to:

* Understand the person’s life history
* Strengthen the practitioner- client relationship
* Use creative, flexible interventions outside of ‘normal’ practice
* Involve the person in the solution
* Promote a multi-agency approach

There is an existing process in the ERSAB area called the ‘Vulnerable Adults Risk Management (‘VARM’) Protocol and Self-Neglect Guidance (2019) which all practitioners and agencies of whom engaged in this SAR were aware of.

The VARM is a good process that facilitates multiagency working with vulnerable adults who are said to have mental capacity but are at risk of harm, including those who are self-neglecting.

William may not have been appropriate to be supported by the VARM framework as other statutory approaches could have helped him before it reached this threshold, however it was not recognised that William was self-neglecting at an early stage to allow these other approaches to be initiated.

**Questions for ERSAB and their partners**

* **How can the practitioners be supported to better identify alcohol-related self-neglect?**
* **Does the ERSAB have a strategic group with responsibility for the self-neglect agenda that includes chronic alcohol use?**
* **How can agencies identify the patterns and characteristics in William’s story (and those of other alcohol related SAR’s) to the current people they support to ensure that alternative and flexible interventions are used that lead to better outcomes?**
* **How can practitioners have better understanding and be able to respond to the long-term needs of people who are dependent drinkers and self-neglect outside of dedicated alcohol services?**
* **Is there a shared understanding between all agencies what the definition of self-neglect is, including that chronic harmful drinking may come under that definition?**

**FINDING TWO:**

**There is a lack of national and local guidance on how to apply safeguarding thresholds to people who self-neglect due to chronic harmful drinking.**

The Alcohol Change UK analysis for ‘*Learning from tragedies: An analysis of alcohol-related Safeguarding Adult Reviews’* (July 2019) recommended that national guidance should be developed on applying safeguarding thresholds to people who self-neglect due to alcohol misuse. It appears there has been no major national progress in response to this recommendation.

William should have been defined as an ‘adult at risk’ in accordance with the Care Act 2014 meaning that he had underlying vulnerabilities in addition to his chronic drinking that should have initiated safeguarding processes.

The reasons William self-neglected were multifactorial including the communication challenges he experienced, underlying mental health problems, chronic loneliness, challenges with finances and a decline in his physical health associated with his chronic drinking.

The current local processes that are underpinned by the Care Act 2014 does recognise self-neglect as requiring a safeguarding approach, but it does not provide a safeguarding specific framework that supports people at an earlier stage other than when it reaches a Section 42 (of the Care Act 2014) threshold or the VARM process.

From around June 2022 until William’s death, there were six separate safeguarding concerns raised with ERYC that included descriptors of self-neglect. None of these concerns were considered to require an urgent safeguarding approach (and thus an urgent welfare visit). A reason given for this was because William’s problems were thought to be due to his chronic drinking, meaning it was a long-term problem and not a ‘new’ urgent need.

Furthermore, it was thought that William’s needs were best approached by offering a Care Act assessment which was thought to be the best way to promote his autonomy, and a letter was sent to William to seek his consent to engage in an assessment.

This approach taken was heavily reliant on William engaging with services rather than there being a recognition that people who self-neglect are likely not to wish to engage in services. In cases of self-neglect services need to develop flexible approaches to deliver intervention in a different way. Sending a letter to William and waiting for him to respond was overly optimistic and did not consider the nuanced approaches that are needed when supporting people who self-neglect.

Some of the practitioners involved in this SAR described the current adult social care system as *fragmented* and explained that a person might be passed to different teams depending on their need throughout their journey. In William’s case when the safeguarding concerns were raised about him they were passed between three different council teams.

Whilst on the one hand this is not conducive to building a trusting relationship with someone who self-neglects, it was also hypothesised this may be why the approach to assessing a person’s level of risk is subjectively influenced. It is understood that ERYC are restructuring their services so that safeguarding practitioners are embedded into each team which is hoped to bring a more integrated approach to safeguarding.

**Questions for ERSAB and their partners**

* **Does this repeatedly identified national issue (in regard to Williams’s SAR and previous others) require onward escalation through the National SAR Escalation Protocol?**
* **Is there currently an appropriate organisational infrastructure in place to support a system aligned to support those who self-neglect and chronically drink to a harmful level?**
* **How can practitioners be trained to understand the complexity of alcohol harm in adult safeguarding?**
* **Are ERYC and ERSAB satisfied that there is a robust safeguarding process in place to support practitioners to make holistic decisions to make safeguarding enquiries when a number of concerns have been raised about one individual?**
* **How can practitioners be supported to develop flexible and creative approaches when working with people who self-neglect and are chronic alcohol drinkers with the understanding that people who self-neglect are likely to not wish to engage?**

**FINDING THREE:**

**Services are currently not resourced in a way that addresses the needs of people with chronic harmful drinking and self-neglect.**

William was offered and received support from alcohol services, but this was reliant on his motivation to change. William was discharged from alcohol services (in 2021) because he did not display this motivation to change his drinking patterns and was then not re-referred to again despite it being recognised as having an increasing impact on his overall wellbeing.

When we consider this within the context of William’s story his alcohol use was chronic (over thirty years) but the requirement for motivation to change overlooked that there were underlying reasons to explain why William drunk alcohol to a harmful level in the first place.

It was likely that because of Williams’s history with alcohol he would have been change resistant and arguably by the time he was physically dependent on alcohol he would not have had much autonomous choice at that point anyway.

When a person is self-neglecting and drinking to a chronically harmful level where they are physically dependent on it (meaning they could have life threatening withdrawals without it), asking them to show motivation to change is unreasonable.

When supporting someone who is self-neglecting and drinking alcohol to a chronically harmful level we must understand their underlying reasons to drink and address that first or in conjunction with any alcohol specific approaches.

William was displaying an emerging picture of vulnerability that required services to work with him under a safeguarding lens and in a more flexible and different way.

Local community alcohol services are not commissioned to provide an assertive outreach approach to people who have a chronic drinking problem, and the service is primarily provided on the basis that the person shows motivation to change and wishes to engage. When we think about this in the context of self-neglect, the current approach does not work.

An assertive outreach approach provides a flexible and persistent method with a key objective to generate a positive relationship and engagement and requires services to accept that working with a person in this way is likely to take time. It is an approach that is much more in keeping with the methodologies of how to support a person who self-neglects.

Over the years William came into contact with a number of health and social care agencies, all of whom completed their own assessments in accordance with William’s presenting need. It appeared that separate agencies believed that the agencies supporting William were more involved and knew more about him than they actually did.

William’s needs around his alcohol use were thought to be the sole responsibility of alcohol services and his physical health needs the responsibility of his GP. Of course, agencies are designed in this way to offer a level of specialism however there could have been a better holistic view of his needs and seeing him as a whole person rather than the particular need a single agency was there to explore.

Services tried to support William with his ‘presenting need’ but did not try to understand and explore what the underlying reasons were for his ongoing drinking by understanding his life story and experience.

William told professionals over the years that he had underlying mental health problems including trauma, obsessive compulsive disorder (OCD) and depression. William received some medication to help with this for a short time but the extent of how this impacted him on a day-to-day level was not fully explored or understood.

William was not referred to mental health services or for psychological support (as first line treatment for OCD as set out by the National Institute for Health and Care Excellence (NICE) guideline for OCD (2005[[3]](#footnote-3)), which would have explored potential underlying reasons for a chronic drinking pattern.

William’s case should be used to challenge the belief that people who drink alcohol to a harmful level need to show motivation to change in order to be supported by alcohol services and used to invite partners to think about more flexible strategies and beliefs as set out in ‘The Blue Light’[[4]](#footnote-4) initiative as designed by Alcohol Change UK.

**Questions for ERSAB and their partners**

* **How can there be strategic and multiagency ownership of supporting people with chronic harmful drinking?**
* **Is there a requirement to escalate and review how alcohol services are commissioned and whether developing a more assertive outreach type model for people with chronic alcohol problems?**
* **Are there gaps in the way that alcohol services are commissioned?**
* **Are services designed to be able to provide longer term resources conducive to building trust and relationships with those people who are chronic alcohol drinkers?**
* **How can ERYC mitigate (insofar as possible) the level of subjectivity when assessing a level of risk?**

**FINDING FOUR:**

**Services are not sufficiently prepared to provide equitable access to information and to communicate with people from the Deaf community.**

If a person is Deaf it does not necessarily mean that they are increasingly vulnerable, however, we do know that disabled adults (Deaf being defined as a disability) are more likely to experience abuse or neglect (Hughes et al, 2012[[5]](#footnote-5)) than those without a disability.

This essential means that there is an increased likelihood that our safeguarding systems will need to work with people who have a disability and adapt their approach to ensure that they access the same equitable service to those without a disability.

According to Hardy (2018[[6]](#footnote-6)) people who are Deaf have reduced opportunities for direct communication without an intermediary. Deaf people are likely to have more limited understanding of written English (or Welsh) (as in William’s story) and should be recognised as a cultural minority and their needs should be met in the same way as working with other cultural groups with a minority language.

William was well known within the Deaf community and sought support from Hull Deaf Centre, and in August 2022, a safeguarding concern was raised to ERYC by a professional at the Hull Deaf Centre which unfortunately was not responded to until after his death. This was a missed opportunity to engage with the Deaf community to increase William’s engagement.

It was recognised by all agencies that William required a BSL interpreter but at times he was still contacted on the phone, he was sent emails, texts, and letters without the recognition this was not his first language, and his understanding of the English language would not be as fluent as expected. It is important to note that English is not always easily translated by BSL which is a language in its own right.

There were some delays in services being able to offer William appointments because he insisted on having a particular interpreter there to support him, so availability needed to be arranged around her.

This is outside of the control of agencies to a certain extent, but William’s experience of having poor access and lack of equitable access to information (compared to a hearing person) over his lifetime may have made him less aware of what support services (and thus what his rights were) outside of his immediate and known support system. This may go some way to explain why William was so insistent on having support from the same people.

William told professionals that he found having too many appointments overwhelming, which he would have found more difficult as he was not always supported by an interpreter. We do not know whether William’s access to information or effective communication impacted on his motivation to work with services, but those services had a responsibility to explore whether this was impacting on his ability to engage rather than just assuming he was making a choice.

It is also important to note that during the timeframe examined services were tackling the restrictions and pressures of the Covid-19 pandemic. It is evident that William found the Covid-19 pandemic difficult with a deterioration in his mental health and increased harmful drinking as a result.

William also reported that he found communicating with others more challenging during the pandemic because of wearing masks and social distancing, and experience he shared with others in the deaf community. Services also found it challenging to support William with his communication needs during the Covid-19 pandemic because of the social distancing and lockdown rules.

During the time period examined, William was also required to register at a new GP surgery due to the previous surgery closing down. There was a notable change in William’s engagement with primary care at this point, and he stopped collecting his prescribed medication.

William appeared to have a good professional relationship with his previous GP and his disengagement with the new surgery may be explained by his challenges in being able to communicate freely and effectively with people he did not know.

Unfortunately, there is a national issue with electronic GP record keeping systems whereby adults who are at risk, or those with vulnerabilities are not flagged to a prescriber if they do not collect their medication or frequently do not attend appointments.

There are significant improvements needed not only locally in the ERSAB area but also nationally to recognise that BSL is a language in its own right, and services need to be prepared to support people who use BSL as it would for any other recognised language.

Attempts were made during the course of this review to engage with Williams’s BSL interpreter but unfortunately it was explained that she could not contribute to this review due her Code of Conduct in accordance with The National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD).

This was a missed opportunity to further understand Williams’s story from her perspective and to seek her personal experiences of how systems worked together to support her. The panel for this review expressed some concern regarding the evident tension between safeguarding responsibilities and the NRCPD Code of Conduct which the ERSAB may wish to further explore.

**Questions for ERSAB and their partners**

* **How can services be better prepared for timely responses when a person requires BSL?**
* **Are all partners satisfied that practitioners are aware of the nuances with the BSL language and information does not translate fully into English?**
* **How can all agencies ensure better awareness that Deaf people are known to have reduced opportunities to engage compared with hearing people?**
* **How can agencies work closer with the Deaf community services?**
* **How can national GP record keeping systems ensure that people with vulnerabilities are flagged to primary care when they register at a different surgery? Does this require escalation through the National SAR Escalation Protocol/NHS Registrations?**
* **How can local and national improvements be made to promote understanding and education so BSL is recognised as a language in its own right?**
* **How can services ensure that patients with disabilities are enabled to make their reasonable adjustments known ahead of any appointments and to ensure that those adjustments are provided?**
* **Is there a requirement to explore and try to resolve the tension between safeguarding responsibilities and the NRCPD Code of Conduct to encourage engagement in SAR processes going forward (both locally and nationally)?**

**Next steps**

A systems learning report does not typically aim to make recommendations (as detailed at the beginning of this report), but it does pose a short number of questions to be considered by the ERSAB and its partners.

The purpose of this approach is to ensure that the actions required to make realistic system level changes are owned by the ERSAB and their partners as agencies who know their services better than a SAR author. It is recommended that the ERSAB and its partners meet to consider Williams’s story and the learning and questions posed to create their own action plan.

National system level learning has also been identified in Williams’s case, and it is recommended that these national issues are escalated into the National SAR Escalation Protocol for wider discussion.

1. <https://www.scie.org.uk/self-neglect/at-a-glance> [↑](#footnote-ref-1)
2. <https://www.scie.org.uk/files/self-neglect/policy-practice/self-neglect_general_briefing.pdf> [↑](#footnote-ref-2)
3. <https://www.nice.org.uk/guidance/cg31> [↑](#footnote-ref-3)
4. <https://alcoholchange.org.uk/help-and-support/training/for-practitioners/blue-light-training/the-blue-light-project> [↑](#footnote-ref-4)
5. Hughes, K; Bellis, M A; Jones, L; Wood, S; Bates, G; Eckley, L; McCoy, E; Mikton, C; Shakespeare, T and Officer, A (2012) [‘Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies’](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2961851-5/abstract) The Lancet, Volume 379, Number 9826, pp1621-29 [↑](#footnote-ref-5)
6. *Community Care,* September 2018, <https://www.communitycare.co.uk/2018/09/19/social-work-d-deaf-people-key-issues-adult-safeguarding/> [↑](#footnote-ref-6)