ROYAL GREENWICH SAFEGUARDING ADULTS BOARD

THEMATIC REVIEW FOLLOWING THE DEATHS OF MAX, CLAIRE and ILIYA

2025

Patrick Hopkinson

TABLE OF CONTENTS

EXECUTIVE SUMMARY THEMATIC REVIEW FOLLOWING THE DEATHS OF Max, Claire and Iliya

Royal Greenwich Safeguarding Adults Board

1. INTRODUCTION

1.1 This thematic Safeguarding Adult Review (SAR) concerns three adults, Max, Claire and Iliya who died between October 2022 and July 2023.

1.2 A summary of agency contacts with the three adults.

1.3 Max

1.4 Max was a Black British man of African-Caribbean origin who was 60 years old when he died. Max lived alone in a council flat on the ground floor. He was unemployed and received state benefits.

1.5 Max had a diagnosis of schizophrenia and was under the care of the Community Team of Oxleas NHS Foundation Trust (Oxleas Mental Health Trust Community Team).

1.6 Max had been detained under the Mental Health Act 1983 on several occasions, both formally and informally. Max's last admission was on 22nd February 2023 to an inpatient ward as an informal patient, following a relapse in his mental health state, which included symptoms of paranoia, grandiose and persecutory delusions, thought disorder, self-neglect and visual hallucinations.

1.7 Max was identified as non-compliant with medication and severely self-neglecting, which included poor food and fluid intake and poor personal hygiene. Max also used cocaine, although the extent of this is not known. A Mental Health Act 1983 assessment was attempted on 11th July 2023 and police officers entered Max's flat but could find no one there. Max was reported as a missing person but was found deceased in a wardrobe at his home on 20th July 2023. Max's cause of death could not be determined.

1.8 Claire

1.9 Claire was a white British woman who was 39 years old when she died.

1.10 Claire experienced low mood, anxiety and agoraphobia and was diagnosed with Emotionally Unstable Personality Disorder. Claire also had a history of alcohol and substance misuse and developed a nasal deformity due to her cocaine use. Claire had also been the victim of domestic abuse, including physical assault, for which her partner was jailed.

1.11 Claire appeared to self-neglect, with poor self-care and her flat was unclean and untidy. Claire had told Oxleas Mental Health Trust Community Team that she had agoraphobia. Claire's mother reported to the Community Team that Claire was self-neglecting and needed to be visited by services at home since Claire would not leave her home. Claire did not attend some medical

appointments for her physical and mental health needs. Claire died at home in October 2022, the day before her circumstances were to be discussed at a multi-disciplinary team. Claire's cause of death was chronic relapsing pancreatitis and micronodular cirrhosis. Chronic alcohol abuse contributed to the cause of death.

1.12 Iliya

1.13 Iliya was 31 years old when he died in June 2023. Iliya was born, and had lived, in Bulgaria and now lived in the UK with his mother and father, who acted as his carers. It appears that prior to registering with a local GP practice in the UK Iliya had a pre-existing diagnosis of paranoid schizophrenia. Iliya spoke little English and communication with Iliya and his mother required a Bulgarian interpreter.

1.14 Iliya's mother reported that Iliya's alcohol intake was "excessive" and that he would not engage with mental health services for fear of being sectioned. Iliya's mother explained that Iliya had experienced a traumatic admission to psychiatric care in Bulgaria. On 27th April 2023 and 30th May 2023, attempts were made by Iliya's GP and ambulance crews to persuade Iliya to accept treatment in hospital for liver disease. However, Iliya refused and was considered by ambulance crews to have the mental capacity to do this. However, after a third attempt on 6th June 2023. Iliya was admitted but died in hospital on 27th June 2023.

1.15 Iliya's cause of death was multi-organ failure, the underlying cause of which was alcoholic liver failure and schizophrenia.

2. Conclusions

2.1 Whilst their individual circumstances differed, Max, Claire and Iliya had life experiences in common. These included mental health needs, substance use (alcohol and / or drugs), self-neglect and trauma in adult life. Claire experienced domestic abuse as an adult and Iliya was reported by his mother to behave aggressively towards her.

2.2 Recognition and responses to domestic abuse

2.3 Claire was a victim of domestic abuse but also had been identified as a perpetrator. Whilst there is no evidence that Claire experienced victim blame by services, it is important to understand the nature of victim blame and ensure that it does not affect responses to domestic abuse. This might also support victims of domestic abuse to feel more confident about reporting abuse. (See Recommendation 1)

2.4 Claire had been assaulted by her partner, John, in September and November 2018. John was prosecuted and imprisoned for the second assault on Claire. When Claire's partner moved to open conditions, restrictions were placed on his contact with Claire. Had Claire known about John's previous common assault in 2014 of his then-partner, either through the "Right to Ask" or "Right to Know" schemes, it may have influenced her decision about whether or not

to withdraw her support for the prosecution of John for the first reported incident of domestic abuse in September 2016. (See Recommendation 2)

2.5 Claire was scared that John would harm her and even kill her when he moved to open prison conditions. On 9th February 2021, when Claire told the police that she was self-harming, Oxleas Mental Health Trust Community Team closed the MERLIN without any further action. Claire had a previous history of self-harming and a suicide safety plan as recommended by the Royal College of Psychiatrists might have been appropriate.

2.6 Recognition and responses to self-neglect

2.7 Self-neglect was recognised by mental health services in Max's and Iliya's case. It is not clear that services recognised that Claire was self-neglecting and the possible relationship between this and her experience of domestic abuse. (See recommendation 1)

2.8 Max, Claire and Iliya do not appear to have received adult safeguarding services, nor were they offered a support and care needs assessment under Section 9 Care Act 2014. Plans were made for Iliya for a mental health assessment under the Mental Health Act 1983. Safeguarding and care and support needs assessment work was delegated to Oxleas NHS Foundation Trust under a s75 agreement and compliance with the requirements of the Care Act 2014 may need to be reviewed. (See Recommendations 3 and 4)

2.9 There may be a need for further development of practice and guidance for working with people who self-neglect, including recognising the signs of self-neglect, the use of history taking, of creating and using moments of motivation, understanding legal powers and duties, and multi-agency working and coordination. (See Recommendation 1)

2.10 Services do not appear have used local practice guidance on self-neglect in relation to multi-agency input. (See Recommendation 1)

2.11 Opportunities to have created moments of motivation for Claire, such as visiting her for mental health appointments and offering a care and support needs assessment. (Recommendations 1 and 4)

2.12 Mental capacity

2.13 No consideration appears to have been given to the impact of both long-term trauma and of alcohol and substance use on cognitive ability and executive brain function. The impact of substance use on mental capacity might have been considered when Max, Claire and Iliya made decisions about where they lived; their safety; their medical care; accepting or refusing treatment; and their own self-care. (Recommendation 1).

2.14 Mental health needs

2.15 The police declined to attend a planned mental health assessment for Max under Section 135 of the Mental Health Act 1983 unless a bed was available for Max in a psychiatric unit. Although there are concerns about the use of

police time, Mental Health Act 1983 assessments, and police attendance, should not depend on bed availability. The police did however attend, when called and used their powers under Section 17 of the Police and Criminal Evidence Act to search Max's property.

2.16 It is not clear what the response to Max's cocaine use was or if there was any enquiry into its impact on his mental health. It is not clear if for Claire there was any interface between substance abuse services and mental health services. (Recommendation 5)

2.17 Engagement

2.18 Agencies struggled to engage with Claire and Iliya. When Max was ill, he appeared aggressive and agencies struggled to find approaches to engage with him in these circumstances. (Recommendation 1)

2.19 Despite advising mental health services that she had agoraphobia and requesting a home visit, Claire was invited to attend a clinic for an assessment. A consequence was that mental health services were unable to assess Claire in her home environment which may have helped to identify the extent of her self-neglect and support needs. (Recommendation 1)

2.20 As Iliya's first language was Bulgarian, Iliya's GP practice arranged for an interpreter for meetings and telephone calls with Iliya and his mother. When Iliya developed jaundice, the GP was able, through an interpreter, to impress upon Iliya and his mother the life threatening nature of his condition, and succeeded in persuading Iliya to agree to be taken to hospital. This was an example of good practice.

2.21 Coordination, multi-agency working and working with family members

2.22 Iliya's mother was his carer but no carer's assessment or support was offered to her. Iliya pressured his mother to buy alcohol for him but this does not appear to have been responded to and the extent to which Iliya's mother was being coerced or controlled does not appear to have been explored. (Recommendation 3)

2.23 A multi-agency, joined up approach was not taken for Max and Iliya nor for the most part for Claire. There appeared to be no social care and adult safeguarding input, which could have offered assessments of care and support needs, new perspectives and may also have been able to co-ordinate multi-agency activity and interventions. (Recommendations 1)

2.24 Actions already taken / in the process of being taken

2.25 Royal Greenwich has developed a Greenwich Suicide Prevention Strategy 2023-28 This could be extended to include the use of suicide safety plans or their incorporation in crisis and contingency plans.

2.26 Oxleas Mental Health Trust uses a therapeutic biopsychosocial approach to mental health treatment as many of its client group have traumatic histories.

2.27 The Right Care, Right Person (RCRP) initiative has been launched to improve access to mental health care. There are now partnership meetings with the AMHP team and the police, chaired by the AMHP team, to manage people waiting for an assessment and which are considered by practitioners to be working well.

2.28 Oxleas Mental Health Trust has made self-neglect and hoarding a specific focus for staff training and awareness during 2024/25. Oxleas Mental Health Trust promotes the use of the Royal Greenwich Safeguarding Adults Board's Self-neglect and hoarding toolkit. Oxleas has trained its staff in recognising cases where multi-agency working should be initiated and how to facilitate this.

2.29 There is an improved working relationship between Oxleas Mental Health Trust and the new VIA drug and alcohol service.

3. Recommendations

The Greenwich Safeguarding Adults Board should seek assurance that:

3.1 **Recommendation 1**: Training packages for mental health and social services staff include modules on trauma informed approaches, avoiding victim blame, the Mental Capacity Act (including an understanding of the role substance dependency can have on capacity) and making services accessible to meet individual needs. Within this training the spirit and ethos of the Royal Borough of Greenwich's "Make Every Opportunity Count" (MEOC) and the NHS "Making Every Contact Count" programmes should be interlinked with engagement, care and support needs assessments, carers' assessments, spotting signs of self-neglect and domestic abuse, and the use of safeguarding interventions.

3.2 **Recommendation 2**: Where an adult discloses domestic abuse to a mental health or social work practitioner, or to the police, as well as making referrals, as appropriate with consent, to other agencies, the practitioner also considers advising the adult of the "Right to Ask" and "Right to Know" (Clare's Law). This measure is recommended to try to ensure that even where an adult does not engage with domestic abuse services (who would normally advise them) they are still made aware of their rights under Clare's law.

3.3 **Recommendation 3**: Practitioners from Oxleas Mental Health Trust and the Royal Borough of Greenwich Social Services offer carer's assessments and young carer's assessments as appropriate, or otherwise, advise and signpost or refer individuals, to services for carers. Although needs will vary and solutions must be tailored to individual circumstances, practitioners undertaking carer's assessments should be aware of practical ways in which carers' needs can be supported and the local and community resources available to them.

3.4 **Recommendation 4:** Royal Borough of Greenwich and Oxleas Mental Health Trust have assessed how effectively the Section 75 agreement is working in delivering, evidencing and assuring the management of safeguarding concerns, care and support needs assessments and carers' assessments.

This could include an assessment of whether performance, practice, structure (the allocation of responsibility and duties), systems (such as procedures) and training for practitioners and their managers are appropriate and effective for fulfilling Care Act 2014 responsibilities.

3.5 **Recommendation 5:** In areas where COMHAD posts are not provided to individuals with co-occurring disorders of mental health needs and substance abuse in secondary teams, Oxleas Mental Health Trust should continue to explore how best it can collaborate with substance abuse services to provide effective interventions for individuals with co-occurring disorders.

4. INTRODUCTION

4.1 This Safeguarding Adult Review (SAR) concerns three adults, Max, Claire and Iliya who died between October 2022 and July 2023.

4.2 This is thematic review, which means that it focuses on themes rather than on each individual and identifies similarities and differences between the lives of Max, Claire and Iliya and the approaches taken by services to engage with and support them. Consequently, it will only consider chronological events where these show a meaningful pattern from which lessons can be learned or where the value of alternative approaches can be illustrated.

4.3 At the request of her mother, Claire's real name has been used in this report. Pseudonyms have been used for the other adults in this report.

4.4 A summary of agency contacts with the three adults.

4.5 Max

4.6 Max was a Black British man of African-Caribbean origin who was 60 years old when he died. Max lived alone in a council flat on the ground floor. He was unemployed and received state benefits. Max's two sisters lived nearby. Their mother had also lived locally, but had died six years prior to Max's death.

4.7 Max had type 2 diabetes, which was treated with metformin. He also had a diagnosis of schizophrenia and had been known to mental health services for several years. Max was under the care of the Oxleas Mental Health Trust Community Team.

4.8 Max had been detained under the Mental Health Act 1983 on several occasions, both formally and informally. Max's last admission was on 22nd February 2023 to an Oxleas Mental Health Trust inpatient ward as an informal patient, following a relapse in his mental health state, which included symptoms of paranoia, grandiose and persecutory delusions, thought disorder, self-neglect and visual hallucinations.

4.9 Max was reported to have been non-compliant with medication and was identified as severely self-neglecting, which included poor food and fluid intake and poor personal hygiene. Max also used cocaine, although the extent of this is not known.

4.10 A Mental Health Act 1983 assessment was attempted on 11th July 2023 with a locksmith and tenancy officer from the Royal Borough of Greenwich (RBG) and an ambulance crew in attendance. Max's door was ajar but no response was received from Max. The flat was in what was described as a squalid condition, with large amounts of rubbish on the floor. At the request of the

Approved Mental Health Practitioner (AMHP), police officers attend, entered and searched Max's flat under section 17 of the Police and Criminal Evidence Act (PACE) 1984. No one was found there.

4.11 On 17th July 2023, six days after the attempted Mental Health Act assessment, Max was reported as a missing person. In the interim, Oxleas Mental Health Trust Community Team and the AMHP service had considered options including raising a safeguarding concern, attempting to arrange a new date for a Mental Health Act assessment and changing the door lock, as well as maintaining contact with Max's sister.

4.12 Max was found deceased in a wardrobe at his home on 20th July 2023. The AMHP team were informed on 21st July 2023 that Max had died.

4.13 Due to the condition of Max's body, no cause of death could be established.

4.14 Claire

4.15 Claire was a white British woman who was 39 years old when she died and had lived in her local authority rented flat for 17 years. Claire had a son when she was a teenager, but separated with the father shortly after the child's birth. When she was 23 years old, Claire moved to the Royal Borough of Greenwich in February 2006 and became a RBG tenant through a mutual exchange with another borough. At that time the only other occupier of Claire's home was Claire's son.

4.16 Claire's mother described Claire as a very talented person who was very skilled at pencil portraits. Claire also had a psychology degree.

4.17 Claire was married by July 2010, but sometime after September 2014 was divorced. Claire then met John in 2016, who became her partner. According to Claire's mother, Claire used to keep her house very tidy but began to neglect her home and herself. In later years Claire stated that she and her son were not in contact. Claire's mother lived abroad and her father in England, but he was not local to Claire.

4.18 Claire experienced low mood, anxiety and agoraphobia and was diagnosed with Emotionally Unstable Personality Disorder. Claire also had a history of alcohol and substance misuse and developed a nasal deformity due to her cocaine use. Claire's mother believes that Claire had undiagnosed schizophrenia, which led Claire to have false recollections about her childhood. Claire's husband had also mentioned to Claire's mother that Claire believed that events she had hallucinated were real. Claire's father paid for a private psychiatrist for Claire, because Claire often would not accept public sector mental health services.

4.19 Claire had experienced domestic abuse from two of her partners. One, Barry, who was Claire's partner when she was 21-22 years of age, was described as having borderline personality disorder and was physically aggressive towards her. The second, John, who became Claire's partner in 2016 and, after approximately four months, stabbed her multiple times, was arrested and sent to prison. Claire was concerned for her own safety when John was moved to

an open prison on 11th May 2020. Claire was also subject to blackmail by another ex-partner, Simon, in 2018.

4.20 Claire appeared to self-neglect, with poor self-care and her flat was unclean and untidy. Claire had told Oxleas Mental Health Trust Community Team, that she had agoraphobia. Claire's mother reported to Oxleas Mental Health Trust Community Team that Claire was self-neglecting, had low body weight, black teeth and matted hair, was not bathing and lived in squalor. Claire's mother said that Claire would need to be visited by services at home as Claire did not leave the property. Claire did not attend some medical appointments for her physical and mental health needs.

4.21 The concerns raised by Claire's mother were due to be discussed at a multi-disciplinary team meeting on 27th October 2022, at which time the team discovered that Claire had died the previous day.

4.22 Claire's cause of death was chronic relapsing pancreatitis and micronodular cirrhosis. Chronic alcohol abuse contributed to the cause of death.

4.23 According to Claire's mother a friend was living at Claire's home. The exact dates when the friend lived there are unclear, and it is also unclear exactly what role the friend played in Claire's life and the events leading up to Claire's death.

4.24 Iliya

4.25 Iliya was 31 years old when he died in June 2023. Iliya was born, and had lived, in Bulgaria and now lived in the UK with his mother and father. Iliya registered with a local GP practice in Autumn 2021. Iliya's registration papers included a handwritten note, in English, of a pre-existing diagnosis of paranoid schizophrenia. The note was provided by Ilya's mother but would seem to have not been written by Bulgarian health practitioners. Iliya's parents acted as Iliya's carers. Iliya spoke little English and communication with Iliya and his mother required a Bulgarian interpreter. Iliya's mother would sometimes defer to Iliya's father for discussions with practitioners, as his father had a greater command of English.

4.26 On 6th October 2021, Iliya was advised by text message to attend his GP surgery for a health check and a blood test.

4.27 On 15th October 2021 Iliya was sent a link to self-register with Mind in Bexley for a forum for people with severe mental illness.

4.28 In February 2022, Iliya's GP practice's mental health practitioner initiated contact and offered Iliya a face to face mental health review for 10th March 2022. Iliya's mother responded but Iliya did not attend. The GP practice added a note to Iliya's file that a Bulgarian interpreter would be needed for contact with Iliya. A GP Registrar review on 1st April 2022 was attended only by Iliya's mother. Iliya's mother reported that Iliya's alcohol intake was "excessive". On 4th April 2022 the GP practice referred Iliya to mental health services having noted Iliya's previously "diagnosed" psychotic disorder.

4.29 There was a further face to face GP appointment on 28th April 2022 which was attended only by Iliya's mother. She reported that Iliya was not drinking much alcohol, did not use drugs, was not violent and spent his days playing computer games. Iliya's mother also reported that Iliya was uncomfortable going out and that he would not engage with services for fear of being sectioned. Iliya's mother explained that Iliya had experienced a traumatic admission to psychiatric care in Bulgaria.

4.30 On 14th December 2022 Oxleas Mental Health Trust Community Team advised Iliya's mother that they could take no action as Iliya was "not cooperating" and that he "did not meet the threshold for sectioning".

4.31 On 29th March 2023, Iliya's mother sent a message to the GP practice to say that Iliya was complaining of pains in his liver and had a small rash on his arms and legs.

4.32 On 27th April 2023 Iliya was visited at home by his GP, who found that Iliya had increased his alcohol consumption. The GP determined that Iliya should go to hospital for investigations and an ambulance was called. Later that day the London Ambulance Service (LAS) telephoned Iliya's GP to advise that the ambulance crew had attended, that Iliya understood the seriousness of his condition (the crew had explained to Iliya that his alcohol use would either be fatal or result in lifelong health problems), but Iliya had refused to go to hospital. The crew assessed that Iliya had the mental capacity to make this decision.

4.33 Iliya was discharged from one part of Oxleas Mental Health Trust Community Team to another on 18th May 2023. The discharge letter to Iliya's GP stated that Iliya had paranoid schizophrenia, was alcohol dependent and had liver disease.

4.34 On 30th May 2023, the LAS attended Iliya's home since Iliya had developed jaundice. Iliya refused to go to hospital. The crew concluded that Iliya had the mental capacity to make this decision. Iliya's mother informed the crew that she would contact a private clinic to arrange for tests to be done at home.

4.35 Following advice from Oxleas Mental Health Trust Community Team on 6th June 2023, Iliya's GP surgery contacted Iliya and his mother and through an interpreter stressed that the situation was critical because Iliya's physical health condition was life threatening. The GP called for an ambulance and sent messages in both Bulgarian and English to Iliya and, separately, to his mother. Included in the message for Iliya's mother was a note that the ambulance crew could assess Iliya's mental capacity. The ambulance crew took Iliya to hospital where he was admitted, although no mental capacity assessment was completed. Iliya died in hospital on 27th June 2023.

4.36 Iliya's cause of death was multi-organ failure, the underlying cause of which was alcoholic liver failure and schizophrenia

5. SAFEGUARDING ADULT REVIEWS

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

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

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

b) the adult has died and the SAB or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died), or

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

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

5.4 If the criteria appear to be met, Safeguarding Adults Boards may agree to proceed with an alternative and more appropriate Review. These Reviews remain statutory Reviews.

5.5 The cases of two of the adults in Greenwich listed in section 1 of this report met the criteria for a mandatory review, and one met the criteria for a discretionary review.

5.6 The SAR Evaluation Group analysed the SAR referral forms relating to three adults and it was agreed by the Independent Chair of the SAB on 14th November 2023 that the three cases be joined together as a Thematic Review with a focus on self-neglect. It was agreed that a Thematic Review rather than individual SARs was the most appropriate way to consider the systemic factors and processes, which may have impacted on the circumstances of the deaths of Max, Claire and Iliya during 2022 and 2023.

5.7 A Thematic Review promotes effective learning, improvement actions and recommendations, which contribute to the improved safety and wellbeing of adults with care and support needs, therefore, reducing the risks of future deaths or serious harm occurring again.

5.8 As with a SAR, Thematic Reviews are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership, and accountability.

5.9 Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances and, a shared action plan to implement these recommendations. It was not the purpose of the Review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

5.10 The Review has followed due process, which has involved: the Independent Reviewer chairing an initial panel meeting to agree the Review terms of reference; analysing the SAR referral forms for the three adults and holding a Practitioner Learning Event made up of representatives of the agencies involved.

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

5.12 The purpose and underpinning principles of this Review are set out in the Royal Greenwich Multi-Agency Safeguarding Adults Policy and Procedures:

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

5.14 The report writer, Patrick Hopkinson, is an independent safeguarding adults review writer, a chair and writer of domestic homicide reviews, and a trainer and consultant in adult safeguarding. He had no connection with any of the organisations that worked with Max, Claire and Iliya.

5.15 Family involvement

5.16 Letters were sent to relatives of the three adults who died inviting them to participate in this Review. Claire's mother asked to participate and met with the SAR author. Claire's mother provided background information on Claire, the salient points of which have been incorporated into this review report.

5.17 Terms of reference for the Thematic Review

5.18 The Thematic Review (and by extension all contributors to the Review) considered and reflected on the following:

- Responses to mental health needs, including communication and AMHP involvement, time frames and time scales. How effective was access to, and use of, Care Act 2014 duties via mental health services.
- Responses to substance use. How was the interface between mental health needs and substance use managed?
- Responses to protected characteristics. Were reasonable adjustments made?

- The identification of, and response to, self-neglect. How were problems of engagement managed and how were interfaces between agencies, including housing managed.
- Provision of, and coordination of work with, housing and accommodation commissioning and provision.
- The understanding, assessment and response to mental capacity and executive capacity, especially in the context of self-neglect.
- Responses to, and leadership in, mental health crisis
- Responses and support to carers and access and use of Care Act 2014 duties.
- Safeguarding responses and escalation. Were single and multi-agency risk management, escalation and coordination processes and forums used?
- The implementation of recommendations from the Royal Borough of Greenwich SARs Mr G (2021), Mr F (2020), Mrs D (2020).
- The Royal Greenwich Safeguarding Adults Board also specifically asked for the theme of domestic abuse to be included within this SAR, even though domestic abuse was known to have been experienced by only one of the three adults subject of this Review.

5.19 Commonalities between the three cases included:

- substance and/or alcohol abuse;
- mental health needs;
- neglect (self-neglect)
- attempts to provide support had met with occasional and sometimes frequent disengagement;

5.20 Max, Claire and Iliya were in contact with various services. These are listed below and include some of the acronyms used in this report:

5.21 Max
- Oxleas NHS Foundation Trust Community Team and inpatient teams
- Police
- Royal Borough of Greenwich – Housing
- GP practice

5.22 Claire
- Police MASH
- Oxleas NHS Foundation Trust Community Team
- Lewisham and Greenwich NHS Trust
- Royal Borough of Greenwich – Housing
- Royal Borough of Greenwich – Safer Communities Team
- GP practice

5.23 Iliya
- Westminster Drugs Project for alcohol addiction (WDP)
- Greenwich Mental Health Hub (GMHH)
- Oxleas NHS Foundation Trust Community Team
- Lewisham and Greenwich NHS Trust (University Hospital (Lewisham) and Queen Elizabeth Hospital (Woolwich)

- London Ambulance Service
- GP practice

5.24 Connecting themes present in adulthood

5.25 Max, Claire and Iliya self-neglected and all had experienced trauma. Max's mother died in 2017, which affected him significantly, Claire experienced domestic abuse, and Iliya, according to his mother, is likely to have experienced trauma as the result of a psychiatric admission in Bulgaria.

5.26 All three adults were drug and/ or alcohol dependent. It appears that Claire may have received some interventions from substance abuse services, but neither Max nor Iliya received treatments and interventions for substance use.

5.27 All three adults had mental health needs, the details of which are known to varying degrees. Claire had a history of suicidal ideation and self-harm.

5.28 Agencies struggled to engage with Max, Claire and Iliya.

5.29 Individual circumstances, which were present for one or more but not all three adults.

5.30 Claire experienced domestic abuse. Iliya may have behaved aggressively to his mother.

5.31 The evidence base for Safeguarding Adults Reviews

5.32 Preston-Shoot (2020) argues that, "Drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. What is proposed here is that SARs begin explicitly with the available evidence-base, using it as a lens with which to scrutinise case chronology and explore through panel meetings, interviews and learning events with practitioners and managers what facilitates good practice and what presents barriers to effective practice".

5.33 The advantage of this approach is that, "The emphasis then is less on description and more on immediate reflection and systemic analysis of facilitators and barriers, across nationally determined policy, legal and financial systems as well as local arrangements and staff values, knowledge and skills" (Preston-Shoot, 2017).

5.34 Reinforcing this, the Local Government Association Analysis of Safeguarding Adult Reviews April 2017 - March-2019 section 3.4 "Type of Reviews" describes a number of "methodological" requirements and related shortcomings of SARs, which can be summarised as follows:

5.35 SARs should connect their findings and proposals to an evidence base. Few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.

5.36 SARs should be based on research. Over 50 Safeguarding Adults Boards have carried out SARs on the same set of circumstances on more than one

occasion but have treated each discreetly. The SARs do not refer to each other, build on each other, or ask why it happened again.

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

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

5.39 Consequently, a study was made of both the research evidence and practice evidence that provides insight and guidance when working with adults like Max, Claire and Iliya.

5.40 The impact of COVID-19

5.41 The first phase of the COVID-19 pandemic began in 2020. On 16th March 2020, the Government advised against non-essential travel and encouraged working from home in all but exceptional circumstances. On 20th March 2020, entertainment venues were also ordered to close.

5.42 On 23rd March 2020, the government restricted contact between households and the UK population was ordered to "stay at home". The only permissible reasons to leave home were food shopping, exercise once per day, meeting medical needs and travelling for work when absolutely necessary. All shops selling non-essential goods were told to close and gatherings of more than two people in public were banned. These 'lockdown' measures legally came into force on 26th March 2020.

5.43 COVID-19 restrictions began to be lifted from 10th May 2020, but local lockdowns were introduced from 29th June.

5.44 During most of 2020 and 2021 Oxleas Mental Health Trust Community Team did not perform home visits unless urgent.

5.45 Section 75

5.46 The duties of adult safeguarding services, and support and care needs assessments for people with mental health needs were, during the time of the events covered by this Review, delegated by the Royal Borough of Greenwich to Oxleas NHS Foundation Trust under a Section 75 agreement. Local authority employed social workers were placed in the Trust's mental health settings as part of the MDT (Multi-Disciplinary Team).

5.47 Co-occurring Mental Health, Alcohol and Drugs (COMHAD)

5.48 Co-occurring Mental Health, Alcohol and Drugs (COMHAD) is a model of distributed resources across Oxleas Mental Health Trust to support people with co-occurring mental health and substance use needs. In accordance with NICE guidance (Overview | Coexisting severe mental illness and substance misuse: community health and social care services | Guidance | NICE) it is

not a specific team but consists of funded COMHAD posts, which are incorporated into different mental health teams.

5.49 COMHAD posts are funded by specific mental health teams and are unevenly distributed. Whilst the number of COMHAD posts has doubled from five to ten over the past two years the resource remains small across mental health teams in three London boroughs and a forensic mental health service.

5.50 Max, Claire and Iliya lived in areas served by mental health teams that did not have COMHAD posts. Oxleas Mental Health Trust stated that people with mental health and substance abuse needs are expected to access and agree to engage with local substance abuse services. Mental health services staff may, however, seek advice from COMHAD in complex cases.

6. THEMATIC ANALYSIS

6.1 Domestic abuse

6.2 Claire experienced domestic abuse. Iliya was reported by his mother to have behaved aggressively, although this was not explored further at the time. There was no evidence, and no consideration of, domestic abuse in Max's life. There is evidence that domestic abuse may have a causal relationship with self-neglect (Tsirigotis and Luczak, 2018; Choi et al, 2009). Factors in this relationship include victims being coerced to meet a perpetrator's needs rather than their own, being made to feel worthless and the consequential trauma of being abused, coerced and controlled.

6.3 Claire – Domestic abuse

6.4 Claire's partner, John had a history of perpetrating domestic abuse and in 2014 had received a caution for common assault against his then partner. It is not clear whether Claire made a DVDS (Domestic Violence Disclosure Scheme – see appendix 1) application to the police about John or whether she was told, or knew, of the scheme. Had Claire made a DVDS application or had the police made a disclosure to her, Claire may have been aware of John's history.

6.5 On 16th September 2016, the police recorded a "domestic" incident between Claire and John. Claire had been physically assaulted by John during an argument. Since Claire's son, who was a child, was present, the police also raised a MERLIN report about him. John was arrested and taken into custody.

6.6 However Claire did not support a prosecution and a no further action was taken. The reasons for Claire's decision are unknown, but perpetrators of domestic abuse frequently use intimidation, coercion and threats of violence or abuse to instil fear to stop their victims from pressing charges. The Duluth Power and Control Wheel, for example, gives examples of the use of power, coercion and control in domestic abuse https://www.dvact.org/post/power-and-control-using-the-duluth-wheel-in-practice.

6.7 Claire told the police that she had tried to separate from John. According to Monckton-Smith (2019), separation and the threat of separation can lead to the abusive partner feeling a loss of control and consequently of status, leading to increased risk of extreme and murderous violence. Victims/survivors of domestic abuse are most at risk of harm and/or homicide from a perpetrator at the point of separation and post-separation.

6.8 On 8th November 2016, John pinned and restrained Claire and begged her to stay with him. John then dragged Claire outside and violently assaulted her with a knife and a glass bottle. Claire sustained serious injuries to her hand which required plastic surgery. John also assaulted Claire's son when he tried to intervene to prevent his mother from being harmed. A further MERLIN report was made by the Police for Claire's son. John was arrested, charged with Grievous Bodily Harm with intent, and remanded in custody until his next court appearance on 8th December 2016.

6.9 A Multi-Agency Risk Management Conference (MARAC) was held on 23rd November 2016, which discussed Claire's situation. There was no mention made at the MARAC of the previous incident on 16th September 2016. John remained on remand until his trial which was originally scheduled to start on 27th March 2017, but was delayed.

6.10 On 15th March 2017 the police completed a MERLIN report since Claire told them that she was very stressed by the delayed trial, that she took Valium daily and that this could make her suicidal. However, Claire refused to speak to anyone from the Domestic Violence Intervention Team (DVIT). Instead Claire was referred to Greenwich Domestic Violence and Abuse Services (GDVA). DVIT was a Royal Borough of Greenwich funded police team which provided intensive support to the highest risk domestic abuse victims.

6.11 John was convicted of assault with intent to cause grievous bodily harm against Claire and assault by beating against her 17 year-old son and sentenced on 7th April 2017 to seven years in prison.

6.12 In January 2018 Claire began a relationship with a man named Simon, whom she had known for 4 years. On 21st May 2018, Simon reported to the police that Claire was bipolar, had suicidal tendencies, anxiety attacks and outbursts, drank 2-3 bottles of wine each day, self-medicated with Valium, used recreational drugs, and had threatened him with a kitchen knife. The police considered this to be controlling behaviour by Claire and gave her a harassment warning. However, this was not referred to the MARAC since there had not been three domestic violence incidents involving Claire within a year; Claire was not recorded on the Police National Computer as a MARAC offender and had not been named as the suspect in a previous MARAC referral.

6.13 Both Claire and Simon worked in the same location. On 15th June 2018 Simon, who was then described as Claire's ex-partner, telephoned Claire and told her that if she went to work he would show her work colleagues videos he had of her. Claire told the police that one of the videos was of an argument between Claire and Simon. Claire had not seen the other videos, but Simon told Claire that they would embarrass her, insinuating that the videos were of

a sexual nature. Claire had not given consent for Simon to film her. The police noted this as blackmail. Claire had originally reported Simon to a manager who had told Claire to report the matter to the police.

6.14 It is not clear to what degree Claire was considered as the victim of domestic abuse or a perpetrator of it. The police had noted that Claire had been blackmailed by Simon, but were aware that Claire had threatened Simon with a knife, only a month earlier, for which a harassment warning had been given to Claire. People involved in abusive relationships do not always fit neatly into categories of "victim" or "perpetrator", despite most responses to domestic abuse being based on this dichotomy.

6.15 What is known of Claire's emotions, thoughts and actions appear consistent with the concept of an abused person feeling as though they are trapped within a "cage" (Stark and Hester, 2019). The cage analogy describes the social and economic inequality forced on women through coercive control. The bars of the cage symbolise an intimate partner's use of controlling tactics including psychological subjugation, strategies of violence, intimidation, isolation, humiliation, exploitation and the micromanagement of their partner's everyday life. Irrespective of whether coercive control includes physical violence, many of these tactics are rarely identified as abuse. Consequently, when victims respond to protect themselves, it can often appear as if they are the perpetrator of abuse.

6.16 Claire was contacted by the National Prison Service Victim Liaison Service in November 2019 as John was due to transfer to open conditions on 11th May 2020 which was a standard determinate release, and his licence was to end on 6th April 2024.

6.17 John's Probation Officer was advised that Claire was very worried that her ex-partner would attempt to kill her once he was released into open conditions. However the transfer went ahead. Victims of crimes cannot prevent transfer to open conditions. The Probation Officer did not have any intelligence to suggest that John had attempted to contact Claire recently, but was still concerned enough to make a MARAC referral on 6th May 2020, since John was to be released on licence on 11th May 2020 to an address outside of Greenwich / Lewisham under the supervision of the Probation Service.

6.18 John did not meet the definition for a MARAC serial perpetrator because he had been heard at a MARAC only once before his attack on Claire in November 2016. He was, however, considered to be a high-risk perpetrator because of his level of violence. John's licence conditions prevented his entry into Claire's postcode area and the London Borough of Lewisham. The police placed "special schemes" on Claire's address due to the known high risk. These meant an urgent response would be made if the police were called.

6.19 Claire was supported by domestic abuse services and engaged well with the Independent Domestic Violence Advocate (IDVA) at the time.

6.20 On 13th October 2020 Claire's GP received a letter from a private psychiatrist about Claire's medication. The letter also mentioned that Claire was afraid that her ex-partner (John) would kill her when he was released. Presumably

this referred to John's move to open conditions which had already taken place at the time of the psychiatrist's letter.

6.21 In 2020 Claire told Oxleas Mental Health Trust Community Team that she had agoraphobia after her "boyfriend" (John) stabbed her several times in November 2016 and subsequently went to prison. Notes taken by Oxleas Mental Health Trust Community Team stated that Claire said she felt better when John was released from prison. Although the notes indicated that there was no contact with John as he was not allowed near her, it is not clear why Claire felt better once he was released, particularly given that Claire had told other agencies that she was afraid of John.

6.22 On 19th July 2022 Claire called 999 and said that her ex-partner, Ray, was threatening to rape her and that he had touched her inappropriately. Claire was described by police as extremely drunk and distressed, and her voice was slurred. Claire told the police that Ray was trying to get her house key from her and that he had pushed her. The police attended Claire's address. Claire had bruises on her arms and legs, but they appeared to be old and Claire gave no reasons for them. There had been no previous incidents between Claire and Ray. Claire retracted her initial allegations and a mutual friend present said that nothing had happened. The police asked Ray to leave, which he did, and took no further action as there was no reason to arrest Ray.

6.23 In summary, services supported Claire with domestic abuse and a successful prosecution was brought against John, who was imprisoned, following his second assault on Claire. When John was due for transfer to open conditions, Claire was informed and John was restricted from visiting Claire's home and local area. Claire was offered support from domestic abuse services, which Claire sometimes engaged with. It is not clear whether Claire made a DVDS application to the police, whether she was notified about John or whether she knew of, or was told about the scheme. Had Claire known about John's previous common assault in 2014 of his then-partner, it may have informed her decision about whether or not to withdraw her support for the prosecution of John for the first reported incident between John and Claire on 16th September 2016.

6.24 Claire was scared that John would harm her and even kill her. Whilst a MARAC was held for Claire to protect her when it was known that John was to be moved to open conditions, and various restrictions were placed upon John's movements so that he was not allowed near to Claire's home, it is unclear what support Claire received in relation to self-harm. Claire had a history of self-harm and suicidal ideation. On 9th February 2021, when Claire told the police she was self-harming, Oxleas Mental Health Trust Community Team closed the MERLIN down without any action, including any action to follow up Claire's report of self-harming and to consider what services they could offer her. A suicide safety plan as recommended by the Royal College of Psychiatrists may have been helpful. Joint working with Claire by mental health and domestic abuse services may also have provided more effective support for Claire.

6.25 A great deal of research has been conducted on the links between domestic abuse and mental health needs. According to SafeLives (2019), mental health problems are a common consequence of experiencing domestic abuse, both for adults and children. And, having mental health issues can render a person more vulnerable to abuse […] Despite these strong associations, domestic abuse is often going undetected within mental health services, and domestic abuse services are not always able to support people with mental health problems.

6.26 People with mental health problems are more likely to be victims than perpetrators of abuse and are at increased risk from perpetrators (Trevillion et al, 2013). Mental health problems can create additional vulnerabilities that people perpetrating domestic abuse may seek to exploit, such as threats of institutionalisation and withholding medication. Where perpetrators have mental health needs, they may use these as a way to excuse the abuse they are perpetrating.

6.27 Research indicates that mental health practitioners are not always equipped to enquire about, and respond to, domestic abuse. Currently, it is estimated that only 10-30% of domestic abuse cases are identified by mental health services (Bradbury-Jones et al, 2014; Greenfield et al, 2025). The reasons for this include:

- Low levels of enquiry
- Lack of training
- Treating symptoms rather than causes

6.28 As part of this Review Oxleas Mental Health Trust has stated that when triaging the large volume of referrals and processing hundreds of Police Merlin Reports a month, Trust staff cannot take the entirety of a patient's history into account. Oxleas Mental Health Trust also commented that there was no "factual" evidence of any suicide attempts and little suicidal ideation expressed throughout Claire's history, which was explored on several occasions. The learning from the Royal College of Psychiatrists, however, is that "The College believe that every person who has self-harmed or is having suicidal thoughts should have a Safety Plan written by them with their health professional, as the Plans are shown to lessen the risk of suicide.'

6.29 Iliya – Domestic Abuse

6.30 Iliya's mother wrote a letter to Iliya's GP stating that Iliya was aggressive. This was the only reference to aggression and there was no opportunity as part of this Review to explore this further with Ilyia's mother. The letter did not specify whether Iliya's aggression was directed against his mother. Practitioners mentioned that Iliya put pressure on his mother to buy him alcohol. This is a theme that has been identified in other Safeguarding Adult Reviews, for example SAR John, City and Hackney Safeguarding Adults Board, 2023.

6.31 Whilst domestic abuse is most frequently considered to take place in intimate personal relationships, it can also occur in non-intimate relationships between adults in the same household and between family members from different generations. This intergenerational abuse disproportionately affects older

people and older women in particular. The *SafeLives* report Safe Later Lives: Older People and Domestic Abuse, for instance, states that "44% of respondents who were 60+ were experiencing abuse from an adult male family member, compared to 6% of younger victims."

6.32 There is no record of that Iliya's mother's concerns were explored further or that support was offered to Iliya's mother**.** This may also have been an opportunity to discuss these concerns directly with Ilyia too.

6.33 Thematic life experiences that Max, Claire and Iliya had in common

6.34 The life experiences that Max, Claire and Iliya had in common were substance abuse (alcohol and / or drugs), mental health needs and self-neglect. Agencies struggled at times to engage with Max, Claire and Iliya. However, with the exception of certain contacts with the police or under certain sections of the Mental Health Act 1983 or provisions of the Mental Capacity Act 2005, all contacts with services were consensual. They took place within a policy context that emphasises choice, independence and personal control and which forms part of an overall neo-liberal Government led approach to adult social care and welfare (Ward et al, 2020).

6.35 Substance abuse

6.36 Max had a known history of cannabis use (it is not clear with what frequency and for how long) and self-declared "lesser" use of alcohol.

6.37 Claire had a history of substance misuse and dependency on polysubstances, alcohol and prescription medication. Claire developed a severe facial disfigurement, which practitioners believed to be due to her long-term use of cocaine.

6.38 Iliya had a history of alcohol abuse and in May 2023, he developed jaundice.

6.39 Mental health needs - Max

6.40 Max had a diagnosis of paranoid schizophrenia. From 17th July 2002 until his death, Max was under the care of Oxleas Mental Health Trust Community Team. Max had been informally and compulsory detained under the Mental Health Act 1983. Max's last admission was on 22nd February 2023 to a Mental Health Trust inpatient ward as an informal patient, following a relapse of his mental state, which included symptoms of paranoia, grandiose and persecutory delusions, thought disorder, self-neglect and visual hallucinations.

6.41 Mental health needs - Claire

6.42 Claire experienced low mood, stress, anxiety and agoraphobia. Claire's contact with mental health services had begun when she was, as her mother recalled, 13 years old. An assessment by the Adult Social Care team in 2009 noted Claire's psychiatric history of relationship difficulties leading to emotional crisis, including recurrent overdoses and cutting herself after relationship breakdown. Claire was considered to use cutting as a "maladaptive coping strategy to relieve dysphoric moods". Claire tended to act

impulsively, which was considered to be consistent with her diagnosis of Emotionally Unstable Personality Disorder (borderline subtype). Claire received several psychological therapies over the years and said that she had not found them helpful. Claire had a significant history of suicidal / depressed behaviour throughout 2020 and low mood, stress, anxiety and agoraphobia. However, Oxleas Mental Health Trust Community Team struggled to engage with Claire to support her with strategies to reduce the risk of self-harm.

6.43 Claire was, however, receiving the services of a private psychiatrist, who wrote to Claire's GP on 13th October 2020 to confirm that they had prescribed Claire "60 days diazepam for anxiety and 30mg mirtazapine". This was an unusual prescription because both medicines have a sedating effect and diazepam is usually recommended for a short period of time (up to four weeks) because of the risks of dependency.

6.44 There were also contacts with the police which brought Claire to the attention of mental health services. For example, on 9th February 2021 a neighbour made allegations to the police about Claire. The police found no evidence to support these allegations, but noted that Claire was still very worried about her ex-partner John's release from prison (which had been in May 2020). The police also considered that Claire had mental health needs and that it was clear that she required extra support. Claire told the police that she was self-harming and that she took more medication than was needed. Other neighbours said that Claire was awake at night. The subsequent MERLIN report was screened by Oxleas Mental Health Trust Community Team, which took no further action because the matter was considered to be a dispute with neighbours. Oxleas Mental Health Trust Community Team's records do not note if Claire's declared self-harm was taken into account in this decision.

6.45 On 8th July 2021 Claire's son (who was away at university) asked the police to make a welfare check on Claire since she was feeling down and had taken 128 tablets. Claire was taken to the emergency department, but she left after five minutes to return home, stating that she had agoraphobia and anxiety. Oxleas Mental Health Trust state that this was not related to Claire's fear of her ex-partner, but was an emotional crisis due to her son being away at university. The police attended Claire at her home and contacted the London Ambulance Service, but Claire refused to go to hospital. The ambulance crew left, but sent a message to the Crisis line to contact Claire.

6.46 The police gained assurance that Claire's "carer" (it is unclear who this was), was going to stay with Claire overnight. The emergency department notified Claire's GP of Claire's attendance there. At Claire's son's request, the Crisis Line contacted Claire on 10th July 2021.

6.47 The Crisis Line contacted Claire very briefly and described her as bright and easy to engage with. Claire said that she was not in crisis, but felt that she had some "issues" to still discuss. Claire explained that she was, however, unable to talk straightaway and would call the Crisis Line back in a few minutes once she was free. The Crisis Line confirmed with Claire that she had its number, but Claire did not call back.

6.48 Mental health needs – Iliya

6.49 Whilst it was understood that Iliya had been diagnosed with paranoid schizophrenia before he moved to the UK from Bulgaria, Oxleas Mental Health Trust stated that Iliya was displaying more signs of physical illness (renal failure) due to alcohol abuse than symptoms of a mental disorder during its interventions.

6.50 Self-neglect

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

6.52 There is extensive research into and guidance on working with people who self-neglect, which was available during the time period for this Review. Guidance on working with people who self-neglect is relevant since it provides insights into approaches to working with people who can be hard to engage. For the purposes of this Review, it is sufficient to focus only on a summary of this guidance. Practice with people who self-neglect is more effective where practitioners:

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

6.53 To do this, the following approaches should be used:

- History taking. Explore and ask questions about how and when self-neglect started.
- Be proactive and identify and address repeated patterns of behaviour

- Try different approaches, use advocates and concerned others, raise concerns, discuss risks, maintain contact, avoid case closure

- Ongoing assessment review of mental capacity.

6.54 Max – Recognition of self-neglect by practitioners

6.55 Max had a history of not allowing practitioners into his home, which appears to have hampered recognition that he was self-neglecting. As his landlord, the Royal Borough of Greenwich (RBG) had to carry out an annual gas safety inspection, and consequently, would obtain a warrant for entry to do this. Max only allowed the inspector in, not the Tenancy Officer. Inspectors are trained in safeguarding and spotting signs to raise an alert. The gas point, however, was in the hallway of Max's home, which meant that the gas safety inspectors did not see the rest of Max's home and may not have picked up on any signs of self-neglect or poor living conditions.

6.56 Mental health services, however, appear to have recognised by 2023 that Max was self-neglecting. It was, for example, noted that Max's last admission to a Mental Health Trust inpatient ward was due to the relapse of his mental state, which included self-neglect and symptoms of psychosis. Max was reported by a ward doctor on 17th March 2023 to have been non-compliant with medication and severely self-neglecting his personal hygiene, with poor food and fluid intake when unwell.

6.57 This recognition, however, does not seem to have led to any action. On 21st April 2023 a Mental Health Trust inpatient ward occupational therapist managed to see into Max's home and raised the risk of self-neglect before Max could deny any other practitioners entry to his home. It does not appear that this led to any action. On 11th July 2023, when contacted by an AMHP, Max's sister reported that Max was "in a very bad way" and was "living in squalid conditions". Max's sister believed that Max's utilities had been cut off since 2020, but the RBG Tenancy team were not aware of this. Max's self-neglect was recognised but did not lead to any further action, including for example, an adult safeguarding intervention or the offer of a care and support needs assessment under Section 9 Care Act 2014.

6.58 Claire - Recognition of self-neglect by practitioners

6.59 There was also a recognition that Claire was self-neglecting. A Police MERLIN report, following an allegation that Claire had been assaulted by a neighbour, was received by Oxleas Mental Health Trust Community Team on 15th July 2022. The MERLIN noted the untidy and unclean condition of Claire's property, Claire's poor self-care and her intoxication with, and dependency on, alcohol. The MERLIN report graded the risk to Claire as Amber. There are four levels of grading, of which Amber is the second highest risk and signifies complex needs which are likely to require longer term intervention from statutory and/or specialist services. Despite this, no care and support needs assessment was offered or made. Claire, however, agreed to social inclusion work and talking therapy from Oxleas Mental Health Trust Community Team.

6.60 Claire told Oxleas Mental Health Trust Community Team that she needed help with housework, but did not engage with scheduled appointments to assess her. It appears therefore that services reported and described circumstances which could be indicators of self-neglect, but it is unclear whether any services, at the time, recognised Claire's behaviours as self-neglecting. Apart from the police, it is unclear whether any service managed to see inside Claire's home in the last few years of her life.

6.61 Claire was visited by her mother, who lived abroad, on 23rd October 2022. Claire's mother tried unsuccessfully to persuade Claire to see her GP for help. Claire's mother did, however, obtain Claire's consent to refer her to Oxleas Mental Health Trust Community Team. Claire's mother emailed Oxleas Mental Health Trust Community Team on 23rd October to report Claire's self-neglect, that Claire was living in squalor and that her shopping was done by a friend. Claire's mother's concerns were due to be discussed in the multi-disciplinary team meeting on 27th October 2022, at which time the team discovered that Claire had passed away the previous day.

6.62 Iliya - Recognition of self-neglect by practitioners

6.63 There was recognition that Iliya was self-neglecting. Iliya refused to take prescribed medication and in 2023 refused to be taken to hospital on several occasions, despite physical signs suggesting the need for medical attention and that Iliya had liver disease associated with his alcohol consumption.

6.64 A letter written by the Greenwich Mental Health Hub on 4th April 2023 identified that Iliya was at high risk of self-neglect and at medium to high risk of self-harm. The letter noted that Iliya had refused to see a GP or to have a blood test or any physical examination. However, no adult safeguarding concern was raised and consequently, no adult safeguarding enquiry was considered or made.

6.65 Attempts to seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience

6.66 Experiences in Childhood

6.67 Claire described her childhood as difficult and that her parents' marital problems had a profound effect on her. Claire had been known to Child and Adolescent mental health services. It was noted that Iliya had traumatic experiences at school in Bulgaria.

6.68 Other than this, it appears that little was known by services of the childhood experiences of Max, Claire and Iliya. This may suggest there was limited history taking by agencies, or exploration, of the nature and impact of experiences during childhood.

6.69 Experiences in Adulthood

6.70 Max – Trauma and the meaning and significance of self-neglect

6.71 Practitioners mentioned during this Review that Max had been significantly affected by the death of this mother, after which he started to decline. Max's sister found it more difficult to engage with him after their mother's death. It is unclear if recognition of the impact of loss influenced approaches taken to support Max. The loss of a loved-one is one of the two most common experiences cited by individuals who self-neglect (the other is being a victim of violence) (Lien et al, 2016).

6.72 A pattern evident in other SARs (for example, SAR "Andrew", Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board, 2022 and SAR "David", also Staffordshire and Stoke ASPB, 2017) is that some men, who are close to their mother and/or rely on their mother for support, are particularly adversely affected by their mother's death, and subsequently self-neglect. Relationships with siblings may not be a substitute for this maternal relationship and, as happened to the relationship between Max and his sister, may become strained.

6.73 Claire – Trauma and the meaning and significance of self-neglect

6.74 Claire experienced Post Traumatic Stress Disorder following a serious physical assault upon her by John. Claire's son was also attacked by John. At the time of her death, Claire had said that she was not in contact with her son. It does not appear that this was known by services other than those in the criminal justice system and the reasons for the estrangement are unknown. It is also not clear to what extent practitioners sought to history take (for example about why Claire was not in contact with her son); to understand the nature and relevance of self-neglect to Claire; or to explore any connections between Claire's experience of domestic abuse and her self-neglect. Claire may also have experienced trauma because of her facial disfigurement. Oxleas Mental Health Trust Community Team made a trauma informed assessment of Claire on 22nd July 2020 and advised her to engage with Westminster Drugs Project. An Oxleas Mental Health Trust plan for Claire, whom it was considered may need psychological therapy, was also to be reviewed. There is no indication that this was actioned. It is unclear if trauma-informed approaches were used to support engagement with Claire.

6.75 Iliya – Trauma and the meaning and significance of self-neglect

6.76 Two different Approved Mental Health Professionals had noted in April 2023 that Iliya's previous mental health hospital admission in Bulgaria had been very traumatic, as Iliya had been "tricked" into consenting to admission when he signed paperwork he had not read and, once admitted, was subjected to mechanical restraint. Oxleas Mental Health Trust has stated that this demonstrated that its practitioners used a trauma informed approach and gave due consideration to the principle of least restriction from the Mental Health Act 1983 Code of Practice.

6.77 The presenting problems of substance use and self-neglect are often coping responses to trauma. Whilst not everyone who has experienced trauma will be affected by it in the long term, there is considerable practice and research evidence that people with a history of trauma struggle to engage with the services that try to help and support them.

6.78 Trauma informed approaches for working with people who have experienced trauma are recommended. See Trauma informed practice and appendix 4.

6.79 How were problems with engagement managed? Responses to protected characteristics and reasonable adjustments.

6.80 Max – engagement and reasonable adjustments

6.81 Max had been known to mental health services for several years and leading up to his death was under the care of Oxleas Mental Health Trust Community Team. There is extensive research evidence for the over-representation (Fearon et al, 2006) of people from an African-Caribbean background in the mental health services in the UK. This is also associated with poorer outcomes (Kreyenbuhl et al, 2009) and negative experiences of mental health services (Morgan et al, 2017; Keating and Robertson, 2004). There is also evidence that these experiences, either first hand or as a third party, can reduce help-seeking (for example, Williams and Steer, 2011). There is also evidence that help-seeking can be influenced by the availability of, often informal, social support (Degnan et al, 2022).

6.82 Max was well known at his doctor's surgery and lived nearby. If he was seen on the street by a doctor or nurse they would invite him into the surgery. Max's GP reflected that in an ideal world GPs could give more time to people like Max and be more community focused. Practitioners reflected that Max was very affable when well, but could be challenging when unwell. Practitioners recognised that this challenge may have been a perception rather than an intention on the part of Max.

6.83 Practitioners also reflected that Max was at his best when supported by the Assertive Outreach Team in 2000. This provided "intensive outreach" and it had worked well because clients could walk in and be seen straight away, rather than have a strict system of appointment times for clients. However, this team no longer exists. Practitioners reflected that it may have been more constructive for Max if he had been given one named individual who he could contact when he needed to.

6.84 Claire – engagement and reasonable adjustments

6.85 Between April 2020 and her death, Claire attended the emergency department on four occasions. During this review, practitioners questioned whether Claire had a formal diagnosis of agoraphobia. Claire had been able to briefly attend the hospital emergency department on 19th and 20th June 2021, which she may not have been able to do if she had agoraphobia. Claire's facial disfigurement caused by long term cocaine use may have resulted in Claire being too embarrassed to go out (for example Hartung et al, 2019; Rifkin et al, 2018). Facial disfigurement can be hard to hide (Bradbury, 2012) and can lead to self-isolation and lack of self-esteem and confidence (Bhandari et al, 2024; Sarwer et al, 2022).

6.86 Agencies struggled to engage with Claire who did not attend planned medical appointments on at least three occasions and had not stayed in the

emergency department to be triaged or receive treatment. On another occasion, Claire became distressed when told that a biopsy was to be taken and left before the procedure was conducted.

6.87 During this Review some practitioners suggested that Claire did not stay when waiting in the emergency department because she needed to satiate her substance dependency. Others commented that it can be a long wait in the emergency department and mental health clients find it challenging to sit by themselves for so long. Claire was prioritised for ENT surgery so that she did not have to wait as a reasonable adjustment.

6.88 Iliya – engagement and reasonable adjustments

6.89 Iliya had recently moved from Bulgaria to the UK. It appears that he and his mother, who had contact with services on Iliya's behalf, spoke little English. Iliya's GP practice, therefore, arranged for an interpreter for meetings and telephone calls with Iliya and his mother. It is not clear why Iliya's father was not involved more given he had a greater command of English.

6.90 Iliya was scared of speaking to mental health professionals for fear of being sectioned and forcibly detained. It is not clear how mental health services in the UK sought to allay Iliya's fears. During the course of this review, Oxleas Mental Health Trust said that their staff follow the five overarching principles of the MHA 1983 code of practice of which the first is using the least restrictive option and helping people to be as independent as possible. An informal admission was offered to Iliya, whose mental capacity to understand the risks and benefits of this was assessed.

6.91 Working patiently at the pace of the individual, but knowing when to make the most of moments of motivation to secure changes.

6.92 Max – Pace of the individual and moments of motivation

6.93 The staff at Max's GP practice felt that more could have been done had they had more time to work with Max. For example, contingency plans for when Max was unwell could have been made with Max when he was well.

6.94 Claire - Pace of the individual and moments of motivation

6.95 Claire told Oxleas Mental Health Trust Community Team that she had agoraphobia on 1st August 2022. Oxleas Mental Health Trust Community Team referred Claire internally and Claire was offered an assessment on 16th September 2022, which would include addressing her agoraphobia. However, Claire did not attend the appointment. Claire was offered another assessment by Oxleas Mental Health Trust Community Team, this time at the team base on 29th September 2022 which Claire did not attend and did not answer her telephone and a message was left for her. Claire telephoned Oxleas Mental Health Trust Community Team back on 30th September 2022 and stated her preference was for a home visit or a telephone assessment because of her agoraphobia, and that she could not leave her home. Claire was told this this request would be considered by a psychiatrist.

6.96 Seemingly unaware of this, on 30th September 2022, a psychiatrist and a nurse from Oxleas Mental Health Trust Community Team reviewed Claire's case. Since there were no records of any suicide attempt or recent self-harm, and a review had indicated that there was low risk to self and others, the conclusion was that an urgent home visit was not required.

6.97 Consequently, Claire received another letter inviting her to an appointment with Oxleas Mental Health Trust Community Team at the team base. There is no indication in Mental Health Trust Community Team records that Claire's preference for a home visit or telephone appointment was discussed. Given Claire's stated preference, and apparent motivation, for a home visit, perhaps another home visit could have been offered to her.

6.98 Claire had also told Oxleas Mental Health Trust Community Team that she needed help with housework. However, there does not appear to have been any follow up on this or an offer of a care and support needs assessment under the Care Act 2014. This may also have been an opportunity to have engaged with Claire.

6.99 Iliya - Pace of the individual and moments of motivation

6.100 In April 2023, Iliya was not sectioned under the Mental Health Act 1983 because he could be supported at home and was willing to engage with treatment in the community including trials of psychotropic medication if necessary (although Iliya did not think these would help him). Iliya was to receive support from Oxleas Mental Health Trust Community Team Trust to prevent his admission to psychiatric hospital.

6.101 Oxleas Mental Health Trust Community Team conducted an outpatient review of Iliya on 5th May 2023 and Mental Health Trust Community Team Trust nurses made two home visits to Iliya facilitated by his parents on 13th and 16th May 2023. The 13th May meeting included an interpreter, which was good practice. However, Oxleas Mental Health Trust Community Team was unable to book an interpreter for the 16th May meeting because of time pressures. On 18th May 2023 Oxleas Mental Health Trust Community Team started to make plans for the provision of psychoeducation and the assessment and monitoring of Iliya's mental state and risks, and for longer-term follow up and care coordination. Iliya was also referred to COMHAD.

6.102 It appears, therefore, a moment of Iliya's motivation was recognised and plans were formulated for a multi-disciplinary team intervention. Iliya, however, died on 27th June 2023 before any assessments, formulation and interventions were made.

6.103 Communicate about risks and options with honesty and openness, particularly where coercive action is a possibility

6.104 Max – Communication about risks and options

6.105 Oxleas Mental Health Trust stated that mental health services were communicating about risks and options with Max, but he had a long history of minimal engagement.

6.106 Claire - Communication about risks and options

6.107 Lewisham and Greenwich NHS Trust stated that its staff were both tenacious and flexible with Claire by offering multiple opportunities to engage for ENT (Ear, Nose and Throat) surgery appointments and by continuing to attempt contact with Claire by telephone when calls went unanswered. The risks, and the need to abstain from drugs before surgery, were explained to Claire who was placed "first on the ENT list". Claire was seen in "priority" clinics and provided with sandwiches and a drink whilst in the clinic and was escorted when leaving.

6.108 Claire had reported self-harm to the police in February 2021. The report from the Tenancy Officer to Oxleas Mental Health Trust on 22nd July 2022 had mentioned that Claire thought of suicide, which Oxleas Mental Health Trust regarded as a "patient safety" rather than a safeguarding concern. It is, however, not clear what action was taken.

6.109 Iliya - Communication about risks and options

6.110 There is some evidence that risks were discussed with Iliya. On 27th April 2023 the London Ambulance Service determined that Iliya had the mental capacity to refuse hospital admission and was aware of the risks of doing so. The crew advised Iliya of the risks of his alcohol use. On 6th June 2023 Iliya's GP impressed upon Iliya and his mother that his condition was life threatening, which led to Iliya's admission to hospital the same day.

6.111 Thinking flexibly about how family members and community resources can contribute to interventions, building on relationships and networks

6.112 Max – Family members and community resources

6.113 Max's sister had found it difficult to engage with, and support, Max especially after their mother's death. Max's family had been supporting Max for at least 20 years and on 11th July 2023 had reported that Max was in "a very bad way". Oxleas Mental Health Trust engaged with Max's sister, but commented that better contact with, and support for Max's family, over a longer timeframe would have been appropriate.

6.114 Claire – Family members and community resources

6.115 Claire's mother began to notify services about Claire's self-neglect towards the end of Claire's life. On 1st August 2022 Oxleas Mental Health Trust Community Team conducted a tele-triage assessment with Claire, during which she mentioned that she had friends, however, there does not appear to have been any follow up of this or approaches to engage these friends. Claire's mother lived abroad and was in occasional contact and Claire's father lived outside of London. Claire was advised to engage with drug and alcohol services, but it appears, without success. Claire's son moved out of Claire's home when he was old enough and was not further involved.

6.116 Iliya – Family members and community resources

6.117 Iliya's mother attended appointments intended for Iliya, on her own. Iliya's mother suggested that convincing Iliya that a medical appointment was for a urine or blood test might make him more relaxed about the appointment. It is not clear whether this approach was used, but it was clear that Iliya did not like his mother making appointments for him. An interpreter was used for appointments with Iliya and his mother, which was good practice. During this review, Oxleas Mental Health Trust commented that without Iliya's parents, engagement with Iliya could not have been possible.

6.118 Working proactively to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals

6.119 There appears to have been little co-ordination and engagement between agencies involved with Max, Claire or Iliya. The Royal Greenwich Safeguarding Adults Board's Self-Neglect and Hoarding Multi-Agency Policy, Practice Guidance and Hoarding Toolkit encourages practitioners to build up good relationships with professionals from other agencies and to ensure that information is shared appropriately, using safeguarding procedures if required. *"A multi-agency approach is often most successful for self-neglect and hoarding cases and leads to improved outcomes for the individual. Co-ordinated responses by social work teams, with the inclusion of other agencies such as housing, mental health, GPs and District Nurses, environmental Health, London Fire Brigade, and the police and family members should be prioritised."*

6.120 Oxleas Mental Health Trust's integrated multi-agency mental health teams include social workers under a Section 75 NHS Act 2006 agreement with the Royal Borough of Greenwich. A multi-agency, joined up approach, however, was not taken for Max and Iliya nor for the most part for Claire. There was no apparent adult social care and adult safeguarding input, which could have offered assessments of care and support needs, new perspectives and may also have been able to co-ordinate multi-agency input and interventions. There had been an opportunity for raising a safeguarding concern when Iliya's mother told Iliya's GP that she had notified adult safeguarding services about Iliya (although this may not have been the case). The GP practice asked Iliya's mother to follow up on the adult safeguarding concern and did not contact safeguarding services directly.

6.121 Substance use services, even if not directly involved with the three adults, may also have brought new perspectives and expertise to multi-agency interventions. It appears that Oxleas Mental Health Trust may have sought advice from COMHAD but it is unclear whether any advice was given or was followed up with further requests.

6.122 Ensuring that options for intervention are rooted in a sound understanding of legal powers and duties

6.123 Max – understanding of legal powers and duties

6.124 Max had intermittently used psychiatric services for some time. Max's last admission to a psychiatric unit was an informal one (not under a section of the

Mental Health Act 1983) and Max discharged himself on 27th April 2023 against ward advice. It appears Oxleas Mental Health Trust inpatient ward was aware of Max's lack of facilities and poor living conditions at home. Under Principle 4 of the guidance on Discharge from mental health inpatient settings there must be a clear plan for the ongoing care, support and housing that the person requires after discharge, which covers their pharmacological, physical health, psychological, social, cultural, education, housing and finances, and any other individual needs or wishes. (See Appendix 2) This applies for informal as well as formal patients. As Max was an informal patient, he was not entitled to free aftercare under section 117 Mental Health Act 1983 (See also Appendix 2). As an alternative, it may have been helpful for practitioners to have assessed Max's care needs and his mental capacity to determine where he should live, or to have his needs met. This may have been an opportunity for multi-agency work on suitable accommodation and support for Max.

6.125 Following Max's self-discharge from hospital on 27th April 2023, Oxleas Mental Health Trust Community Team was to continue to monitor Max's mental state and physical wellbeing, and Max was to attend a clozapine clinic. Zoning and MDT discussions were held fortnightly. Zoning meetings (a term used locally) provide a snapshot of the mental health team case load. Zoning meetings use a RAG rating scale for each service user to assess whether they should be seen more regularly by mental health services.

6.126 The Care Programme Approach was used for case review (Care for people with mental health problems (Care Programme Approach) - Social care and support guide - NHS (www.nhs.uk)). This is being replaced in practice by The Community Mental Health Framework (CMHF) (community-mental-health-framework-for-adults-and-older-adults.pdf (england.nhs.uk))

6.127 A Mental Health Act 1983 assessment was planned for Max for 11th July 2023 and a Section 135(1) warrant was to be executed to convey Max from his home to hospital to do this. It is standard practice and lawful to request police attendance in these circumstances. However, police officers would not attend unless it was clear there would be a bed available for Max on a psychiatric unit. The availability of a bed could not be confirmed and police did not attend. The Section 12 Mental Health Act 1983 doctors and the care co-ordinator did, however, attend Max's home. There was no answer from Max. The police were then called, who entered Max's home but found no one there. During the course of this review, practitioners noted that making a Mental Health Act 1983 assessment should be given priority over the availability of a bed. The bed may not be needed after the assessment and should not be a factor in the assessment process. The police commented that delays in waiting for a bed following a Mental Health Act 1983 assessment puts extra pressure on police resources. Since Max's death, there are now partnership meetings with the AMHP team and the police, chaired by the AMHP team, to manage people waiting for an assessment and which are considered by practitioners to be working well.

6.128 Understanding of legal powers and duties – Mental Capacity

6.129 Mental capacity assessments were completed for Iliya only. There was no formal mental capacity assessments of Max and Claire, but a Mental Health Trust Community Team nurse stated that Claire had the mental capacity to understand information and use or weigh and make informed decisions. Claire and Max both self-neglected and it might have been appropriate to have conducted mental capacity assessments in the context of Max's and Claire's substance use and self-neglect.

6.130 It is unclear if Max, Claire and Iliya were considered to be making unwise decisions. The Mental Capacity Act 2005 does not give the right to make unwise decisions and instead, unwise decisions, especially if they appear to be harmful are an opportunity to assess mental capacity. There were opportunities when a capacity assessment might have been useful. Examples include when appointments were not attended, where there were repeating patterns of behaviour and where there were other signs of self-neglect. There does not appear to have consideration of the extent to which Max, Claire and Iliya had the mental capacity to make their own decisions about where they lived, their safety, their medical care, accepting or refusing treatment, and their own self-care.

6.131 Substance Use and Mental Capacity

6.132 The Mental Capacity Act 2005 sets out the process for assessing and determining whether or not someone who has an "*an impairment of, or a disturbance in the functioning of, the mind or brain*" is able to make a specific decision at a specific time. Impairments and disturbances in functioning of the mind or brain can result from drug and alcohol use and addictions to them was well as the coercive and controlling influence of others.

6.133 Whilst the Mental Capacity Act 2005 does not explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice.

6.134 There is growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation) which in turn impacts on mental capacity. Approximately 50% of dependent drinkers have frontal lobe damage. Compared with control groups, people with frontal lobe damage caused by alcohol use and traumatic experiences:

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

6.135 As a result, people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening. Significantly, these cognitive deficits are unlikely to be detected using the verbal reasoning tests frequently used in mental capacity assessments.

6.136 The Alcohol Change UK report, Safeguarding Vulnerable Dependent Drinkers in England and Wales (Ward and Preston-Shoot) identifies that at times dependent drinkers may be wrongly believed to have mental capacity to make decisions about their safety. The Mental Capacity Act 2005 defines the ability to make a decision as the ability to understand relevant information; to retain that information; to use or weigh that information as part of the decision-making process; and to communicate the decision. If a person is unable to do any one of these, then they are unable to make the decision in question.

6.137 However, for dependant drinkers, "*their compulsion to drink means that they are unable to use the information they are given, even if they understand it*" (Ward and Preston-Shoot).

6.138 The Alcohol Change report also highlights that a long-term view should be taken when assessing capacity, which includes the history of decisions that a person has made, which might have been based on their lack of understanding of risks, or inability to weigh up information. In these situations, it his helpful to consider Mental capacity as a "video" rather than as a "snapshot".

6.139 Max, Claire and Iliya self-neglected and had histories of alcohol and/or drug misuse, which for contributed to the deaths of Claire and Iliya. The cause of death for Max is awaiting the outcome of an inquest.

6.140 There does not appear to have been an operational understanding of the impact of substance addiction upon Max, Claire or Iliya's decision making. Their dependence on alcohol and drugs could have been considered to have caused a disturbance to the functioning of the mind or brain which might be affecting their ability to make decisions. This approach is promoted by the Alcohol Change UK December 2020 report, "Safeguarding Vulnerable Dependent Drinkers".

6.141 Responses to substance use and how the interface between mental health needs and substance abuse was managed.

6.142 Cocaine and other substances may affect mental health needs and also the effectiveness of mental health treatments. (See Appendix 3 for effects of cocaine use.) There was a small and minimally funded Co-occurring Mental Health, Alcohol and Drugs (COMHAD) model which did not cover the areas in which Max, Claire or Iliya lived. Research evidence (for example Guyer et al, 2024) has shown that at least half of all people with mental health needs who are receiving treatment also have co-existing substance use needs. Despite this, the majority of mental health services and substance use services are commissioned, provided and operate separately from each other.

.

6.143 Max – responses to substance use

6.144 Max's history of cannabis use was known to Oxleas Mental Health Trust together with a self-declared history of "lesser" alcohol use. It is not clear what the response to Max's cocaine use was or if there was any enquiry into what impact it had on his mental health. Oxleas Mental Health Trust stated that a COMHAD "referral" for Max was discussed on 6th June 2023. Presumably this was for mental health services to seek advice from COMHAD. The Trust did not, however, state what happened to this referral.

6.145 Claire – responses to substance use

6.146 Claire had a history of alcohol and substance use and was described by Oxleas Mental Health Trust as dependent on prescription medication. Claire's GP was, however unaware of Claire's alcohol use and during the course of this Review commented that alcohol use does not always show up in blood tests for young people. Oxleas Mental Health Trust Community Team completed a trauma informed assessment of Claire on 22nd July 2020, which included a referral to, and advice on engaging with, the WDP (Westminster Drugs Project). Claire had a telephone assessment with WDP on 10th August 2020. It is not clear what the outcome was and what treatment Claire received. On 1st August 2022, Claire attended an Alcoholics Anonymous meeting. On 10th May 2022, Claire told a Lewisham and Greenwich NHS Trust practitioner, when booked for ENT surgery, that she drank a quarter of a bottle of vodka a day, smoked 30 grammes of tobacco a day and was not using cocaine. On 17th June 2022, however, Claire informed the ENT doctors that she was using cocaine. The doctors advised Claire that she must abstain for a year in order to have reconstructive surgery. It is not clear, however, that there was any joint working with substance abuse services and mental health services to support this.

6.147 Iliya – responses to substance use

6.148 In April 2022, Iliya was to be referred to the WDP for alcohol addiction, but in May 2023 was noted by Oxleas Mental Health Trust Community Team to have refused help. It seems that at that time Iliya had already been diagnosed with liver disease and had developed jaundice. On 27th April 2023, when an ambulance was called, the crew advised Iliya that he may die from alcohol abuse, but Iliya refused to go to hospital until 6th June 2023, after Iliya's GP had impressed the life threatening nature of his condition upon Iliya and his mother. A "referral" to COMHAD was also discussed on 6th June 2023 and the MDT at Oxleas Mental Health Trust Community Team would invite the local allocated COMHAD nurse to a joint visit to Iliya's home with the aid of an interpreter. However, Iliya was admitted to hospital on 6th June 2023 and died there from multiple organ failure caused by alcoholic liver disease on 27th June 2023.

6.149 In summary, it appears that neither Max, nor Iliya received direct support from substance abuse services. Iliya refused help from the WDP. Claire had a telephone assessment with WDP, but it is not clear if she had further involvement with WDP. Oxleas Mental Health Trust had planned or discussed seeking advice from COMHAD for Max and Iliya which was good practice, but

this did not happen before their deaths. Services may have been hampered by the limited funding of COMHAD and by their struggles to engage with Max, Claire and Iliya. Mental health and substance use services for Max, Claire and Iliya do not appear to have been integrated.

6.150 Responses and support to carers and access and use of Care Act 2014 duties.

6.151 Max's sister was identified as Max's carer. However, Oxleas Mental Health Trust's notes did not link Max with his sister. Max's sister was not provided with a carers information pack, invited to join a carers group or offered a carer's assessment under s10 Care Act 2014.

6.152 Claire's son should also have been considered as a carer for Claire when he was living with her (Being a young carer: your rights - Social care and support guide - NHS (www.nhs.uk)).

6.153 Iliya lived with his mother and father, who acted as his carers. Iliya provided permission for services to speak to his parents which constituted sharing his information, but his parents were not offered carers assessment to which they were entitled under s10 of the Care Act 2014.

6.154 On 26th July 2022, Iliya's mother disclosed to the GP surgery by letter that Iliya had become aggressive when he found out that he was to have a home visit from mental health services (the team was not identified in the letter). Iliya blamed his parents for his mental health diagnosis, which he did not agree with. It is not clear from the letter whether Iliya was aggressive towards his mother. There was an entry in the GP's notes that Iliya's mother was to contact the police if she felt unsafe. The GP forwarded the letter to mental health services (it is not clear which team). Iliya's mother had apparently informed local authority safeguarding services about Iliya, although it is unclear about what this had involved, and Iliya's mother was advised by the GP to follow up adult safeguarding services. In December 2022, Oxleas Mental Health Trust Community Team told Iliya's mother that if Iliya was "not cooperating" and he did not meet the threshold for sectioning they could do nothing more. During the course of this Review, practitioners commented that Iliya's mother was under a lot of pressure because Iliya wanted her to buy him alcohol and was aggressive towards her. According to practitioners no help was offered to Iliya's mother in response to this and there does not appear to have been consideration that Iliya's mother (or father) might be experiencing intergenerational domestic abuse.

6.155 Making Every Opportunity Count

6.156 The Royal Borough of Greenwich has a "Make Every Opportunity Count" programme which encourages public facing staff in Greenwich to take opportunities in their everyday conversations and interactions with the public to support residents to take full advantage of public services. Similarly, the NHS has an initiative, the "Making Every Contact Count" programme. This approach encourages health and social care staff to use the opportunities presented during their routine interactions with "patients" for conversations about improving health and wellbeing. It may be helpful to apply the spirit and

ethos of these initiatives when working with people who self-neglect, who services struggle to engage with and who may be experiencing domestic abuse. These include care and support needs assessment, carers' assessments, spotting signs of self-neglect, and use of safeguarding interventions.

6.157 Provision of, and coordination of work with, housing and accommodation commissioning and provision

6.158 The terms of reference for this Review include consideration of the role of the Royal Borough of Greenwich (RBG) housing services, including commissioning. RBG housing does not commission housing except in some cases of temporary accommodation, where existing tenants have to be moved out while repairs are carried out.

6.159 Both Max and Claire were local authority tenants within the Borough. Iliya lived with his mother and father and was not a local authority tenant.

6.160 Good Practice

6.161 On 6th June 2023 Iliya's GP impressed upon Iliya and his mother, using an interpreter, that Iliya's condition was life threatening, and as a result persuaded Iliya to go to hospital. Iliya had refused to go to hospital on previous occasions.

6.162 Both Iliya's GP and Oxleas Mental Health Trust used interpreters. This was good practice.

6.163 During the course of this Review practitioners commented that carers from ethnic minority backgrounds can find it hard to engage with services. Oxleas Mental Health Trust said that a consultant on one of their wards ran a group for ethnic minority carers and that services should continue to explore such initiatives.

6.164 Oxleas Mental Health Trust identified that it was good practice for mental health services to take Claire's entire history into account including from the Child and Adolescent Mental health Service (CAMHS) and her "Rio" entries dating back to 2007, which demonstrated that community based interventions were offered throughout.

6.165 Given that Max, Claire and Iliya were not eligible for direct services from COMHAD, it was good practice for Oxleas Mental Health Trust to have discussed referrals and sought advice from a COMHAD practitioner for Max and Iliya.

7. Conclusions

7.1 Whilst their individual circumstances differed, Max, Claire and Iliya had life experiences in common. These included mental health needs, substance use (alcohol and / or drugs), self-neglect and trauma in adult life. Claire

experienced domestic abuse as an adult and Iliya was reported by his mother to behave aggressively towards her.

7.2 Recognition and responses to domestic abuse

7.3 Claire was a victim of domestic abuse but also had been identified as a perpetrator. Whilst there is no evidence that Claire experienced victim blame by services, it is important to understand the nature of victim blame and ensure that it does not affect responses to domestic abuse. This might also support victims of domestic abuse to feel more confident about reporting abuse. (See Recommendation 1)

7.4 Services tried to support Claire with domestic abuse. A successful prosecution was brought following her partner John's second reported assault on 8th November 2016, for which John was imprisoned. Claire was notified when John was due for transfer to open conditions and special conditions were placed on John restricting him from visiting Claire's home and local area. Claire was offered support from domestic abuse services, which Claire sometimes engaged with. It is not clear whether Claire made a DVDS application to the police, whether she knew of the scheme or if the police disclosed John's history of abuse to Claire. Had Claire known about John's previous common assault in 2014 of his then-partner, it may have influenced her decision about whether or not to withdraw her support for the prosecution of John for the first reported incident of domestic abuse on 16th September 2016. (See Recommendation 2)

7.5 Claire was scared that John would harm her and even kill her when he moved to open prison conditions. On 9th February 2021, when Claire told the police that she was self-harming, Oxleas Mental Health Trust Community Team closed the MERLIN without any further action. Claire had a previous history of self-harming and a suicide safety plan as recommended by the Royal College of Psychiatrists might have been appropriate.

7.6 Recognition and responses to self-neglect

7.7 Self-neglect was recognised by mental health services in Max's and Iliya's case. Iliya was described as at "high risk" of self-neglect. The police described indicators of Claire's self-neglect, but it is not clear that services recognised that Claire was self-neglecting and the possible relationship between this and her experience of domestic abuse. (See recommendation 1)

7.8 Neither Max nor Claire appear to have received adult safeguarding services, nor were they offered a support and care needs assessment under Section 9 Care Act 2014, despite the signs of self-neglect and, their apparent need for care and support. Similarly, Iliya was not referred for a needs assessment, nor did he receive safeguarding services but plans were made for a mental health assessment under the Mental Health Act 1983. Safeguarding and care and support needs assessment work was delegated to Oxleas NHS Foundation Trust under a s75 agreement and compliance with the requirements of the Care Act 2014 may need to be reviewed. (See Recommendations 3 and 4)

7.9 There may be a need for further development of practice and guidance for working with people who self-neglect, including recognising the signs of self-neglect, the use of history taking, of creating and using moments of motivation, understanding legal powers and duties, and multi-agency working and coordination. (See Recommendation 1)

7.10 Services do not appear have used the Royal Greenwich Safeguarding Adults Board's Self-Neglect and Hoarding Multi-Agency Policy, Practice Guidance and Hoarding Toolkit in relation to multi-agency input. (These were published on the SAB website and dated September 2022 and so were available during only some of the time covered by this SAR) (See Recommendation 1)

7.11 On 28th June 2023 the AMHP service noted that a Section 42 Care Act 2014 safeguarding enquiry was required for Max, but none was made. It is not clear why an enquiry was not made. (See Recommendation 4)

7.12 Care and support needs assessments and carer's assessments could have been offered, and safeguarding and self-neglect protocols used, in line with the ethos and spirit of Making Every Opportunity / Contact Count programmes. (See recommendations 1 and 3)

7.13 Practitioners stated that Claire did not have moments of motivation. However, there may have been opportunities to have created moments of motivation. These include visiting Claire at home for her mental health appointments and by offering a care and support needs assessment. (Recommendations 1 and 4)

7.14 Mental capacity

7.15 On three occasions mental capacity assessments were completed for Iliya, once by mental health services (to check that Iliya understood the risks and benefits of an informal admission to a psychiatric unit) and twice by ambulance crews. No mental capacity assessments were conducted for Max and Claire. No consideration appears to have been given to the impact of both long-term trauma and of alcohol and substance use on cognitive ability and executive brain function. The impact of substance use on mental capacity might have been considered when Max, Claire and Iliya made decisions about where they lived; their safety; their medical care; accepting or refusing treatment; and their own self-care. (Recommendation 1).

7.16 Mental health needs

7.17 The police declined to attend a planned mental health assessment for Max under Section 135 of the Mental Health Act 1983 unless it was confirmed beforehand that there would be a bed available for Max in a psychiatric unit, should he be sectioned. Although there are concerns about the use of police time, Mental Health Act 1983 assessments, and police attendance, should not depend on bed availability. The police did however attend, when called and used their powers under Section 17 of the Police and Criminal Evidence Act to search Max's property.

7.18 It is not clear what the response to Max's cocaine use was or if there was any enquiry into its impact on his mental health. It is not clear if for Claire there was any interface between substance abuse services and mental health services. It is also unclear if advice was received from COMHAD. Claire was never discharged from the ENT service, a service which Lewisham and Greenwich NHS Trust described as "flexible" and which continued to send her appointment letters. Claire was taken off the awaiting surgery list, however, when the ENT department learned from Claire that she had recently been using cocaine. (Recommendation 5)

7.19 Engagement

7.20 Agencies struggled to engage with Claire and Iliya. When Max was ill, he appeared aggressive and agencies struggled to find approaches to engage with him in these circumstances. (Recommendation 1)

7.21 Claire did not attend medical appointments, she had left the emergency department on four occasions and did not stay to be triaged or treated. Despite advising mental health services that she had agoraphobia and requesting a home visit, Claire was invited to attend a clinic for an assessment. A consequence was that mental health services were unable to assess Claire in her home environment which may have helped to identify the extent of her self-neglect and support needs. (Recommendation 1)

7.22 As Iliya's first language was Bulgarian, Iliya's GP practice arranged for an interpreter for meetings and telephone calls with Iliya and his mother. When Iliya developed jaundice, the GP was able, through an interpreter, to impress upon Iliya and his mother the life threatening nature of his condition, and succeeded in persuading Iliya to agree to be taken to hospital. This was an example of good practice.

7.23 Coordination, multi-agency working and working with family members

7.24 Iliya's mother was his carer but no carer's assessment or support was offered to her. Iliya's mother was pressured by Iliya to buy alcohol for him but this does not appear to have been responded to and the extent to which Iliya's mother was being coerced or controlled does not appear to have been explored. (Recommendation 3)

7.25 There appears to have been little co-ordination and engagement between agencies. Iliya's mother told Iliya's GP that she had notified adult safeguarding services about her son. The GP practice asked Iliya's mother to follow up on the adult safeguarding concern and did not contact safeguarding services directly.

7.26 A multi-agency, joined up approach was not taken for Max and Iliya nor for the most part for Claire. There appeared to be no social care and adult safeguarding input, which could have offered assessments of care and support needs, new perspectives and may also have been able to co-ordinate multi-agency activity and interventions. (Recommendation 1)

7.27 Actions already taken / in the process of being taken

7.28 Royal Greenwich has developed a Greenwich Suicide Prevention Strategy 2023-28 which has nine key areas for action. Three of these key areas concern the identification of people at risk of suicide and the provision of support to them; work with communities to provide earlier intervention and support to reduce the risk of mental health crisis and suicide; and improving the effectiveness of services for people at risk of suicide and mental health crisis. This work could be extended to include the use of suicide safety plans or their incorporation in crisis and contingency plans.

7.29 Oxleas Mental Health Trust uses a therapeutic biopsychosocial approach (a holistic approach to understanding health and illness, considering the interconnectedness of biological, psychological, and social factors) to mental health treatment as many of its client group have traumatic histories. The Trust has made a trauma informed care eLearning training package available to all staff.

7.30 Since Max's death the Right Care, Right Person (RCRP) initiative has been launched which aims to improve access to mental health care and to allow police officers to focus upon preventing and solving crime. Since Max's death, there are now partnership meetings with the AMHP team and the police, chaired by the AMHP team, to manage people waiting for an assessment and which are considered by practitioners to be working well.

7.31 Oxleas Mental Health Trust has made self-neglect and hoarding a specific focus for staff training and awareness during 2024/25. Oxleas Mental Health Trust promotes the use of the Royal Greenwich Safeguarding Adults Board's Self-neglect and hoarding toolkit.

7.32 Oxleas Mental Health Trust has trained its staff in recognising cases where multi-agency working should be initiated and how to facilitate multi-agency approaches.

7.33 Oxleas Mental Health Trust has embedded exploration of substance abuse issues with mental health service users. Oxleas Mental Health Trust works closely with substance abuse services.

7.34 COMHAD resource increases have been in primary mental health services (Hubs). There is no COMHAD post to support secondary teams. However, although Oxleas Mental Health Trust has not expanded COMHAD posts for secondary mental health services, there is an improved working relationship between Oxleas and the new VIA drug and alcohol service. This includes a regular interface meeting, increased pathways for consultative communication, joint reflective practice meetings, representation at the Royal Borough of Greenwich Combatting Drug Partnership and Drug and Alcohol Death Panel and increased COMHAD and medical education training. Oxleas Mental Health Trust also piloted a post to embed a mental health practitioner within the VIA drug and alcohol service from October 2023 to 2024 to improve access to mental health interventions for people with substance use needs and also to improve the information exchange pathways between VIA and secondary teams.

7.35 Action Plan resulting from recommendations in SAR Mrs D

7.36 The action plan developed by the Safeguarding Adults Board in relation to the SAR of Mrs D required that all health care services should promote the use of carer's assessments and keep records where these are refused, including prompts to reoffer these. A specific action under this heading was for Oxleas Mental Health Trust to ensure that carer's assessments are recorded and support networks identified if part of the person's care. Oxleas now completes a "support network tool" for nearly all patients which captures any support involved in a person's care. In addition, as part of the patient experience feedback, service users are asked if they had requested someone from their support network to be involved in their care. If they had requested someone they are then asked if that happened for them.

7.37 All services were to consider their oversight of patient and carer cancelled appointments, when there are multiple cancelled appointments. Oxleas Mental Health Trust now has a system where cancelled appointments twice in a row are flagged to consultants to decide on further action.

7.38 The Mrs D action plan also recommended the consideration of developing specific guidance for health and social care professionals in cases where there is apparent engagement from a person's family, but where there may be disguised compliance, for example, guidance on lack of access to a person's home and repeated cancelled appointments. A Safeguarding Adults Multi-Agency Self Neglect and Hoarding Policy has been developed which gives guidance on non-engagement and supporting people who self-neglect.

7.39 Action plan resulting from the recommendations in SAR Mr F

7.40 The Mr F action plan included new mandatory training for all clinical and adult social services staff on the Mental Capacity Act. This includes the use of mental capacity assessments where there are concerns that a person's physical disabilities affect their decision making, for example, on consent for/refusal of health care treatment. Implementation of this training was completed in September 2021 and staff are required to undertake this training every three years.

7.41 When considering the learning from this thematic review, it may be appropriate to ensure that MCA training includes the effects of coercion and control, long-term substance use, or trauma on mental capacity

7.42 Action plan resulting from the recommendations of the Mr G SAR.

7.43 A self-neglect and hoarding policy was created and circulated to partners and care homes. A self-neglect conference was held in November 2022.

8. Recommendations

Building on the conclusions set in section 4, the following recommendations are made. The Greenwich Safeguarding Adults Board should seek assurance that:

8.1 **Recommendation 1**: Training packages for mental health and social services staff include modules on trauma informed approaches, avoiding victim blame, the Mental Capacity Act (including an understanding of the role substance dependency can have on capacity) and making services accessible to meet individual needs. Within this training the spirit and ethos of the Royal Borough of Greenwich's "Make Every Opportunity Count" (MEOC) and the NHS "Making Every Contact Count" programmes should be interlinked with engagement, care and support needs assessments, carers' assessments, spotting signs of self-neglect and domestic abuse, and the use of safeguarding interventions.

8.2 **Recommendation 2**: Where an adult discloses domestic abuse to a mental health or social work practitioner, or to the police, as well as making referrals, as appropriate with consent, to other agencies, the practitioner also considers advising the adult of the "Right to Ask" and "Right to Know" (Clare's Law). This measure is recommended to try to ensure that even where an adult does not engage with domestic abuse services (who would normally advise them) they are still made aware of their rights under Clare's law.

8.3 **Recommendation 3**: Practitioners from Oxleas Mental Health Trust and the Royal Borough of Greenwich Social Services offer carer's assessments and young carer's assessments as appropriate, or otherwise, advise and signpost or refer individuals, to services for carers. Although needs will vary and solutions must be tailored to individual circumstances, practitioners undertaking carer's assessments should be aware of practical ways in which carers' needs can be supported and the local and community resources available to them.

8.4 **Recommendation 4:** Royal Borough of Greenwich and Oxleas Mental Health Trust have assessed how effectively the Section 75 agreement is working in delivering, evidencing and assuring the management of safeguarding concerns, care and support needs assessments and carers' assessments. This could include an assessment of whether performance, practice, structure (the allocation of responsibility and duties), systems (such as procedures) and training for practitioners and their managers are appropriate and effective for fulfilling Care Act 2014 responsibilities.

8.5 **Recommendation 5:** In areas where COMHAD posts are not provided to individuals with co-occurring disorders of mental health needs and substance abuse in secondary teams, Oxleas Mental Health Trust should continue to explore how best it can collaborate with substance abuse services to provide effective interventions for individuals with co-occurring disorders.

Appendices

Appendix 1: Domestic Violence Disclosure Scheme (DVDS)

APPENDIX: Clare's Law is officially known as the Domestic Violence Disclosure Scheme (DVDS) and was introduced in 2014. The scheme was named after Clare Wood, who was murdered by her ex-boyfriend in 2009. Under the DVDS, a person can apply to the police to determine if their current or ex-partner has a history of domestic violence and is known as the "Right to Ask". If police checks confirm that a person has a history of abusive or violent behaviour, then they may decide to disclose some of that information to the person enquiring. Under the "Right to Know" part of the scheme, police may make a disclosure of their own initiative if they receive information about the violent or abusive behaviour of a person which may have an impact upon the person's partner or ex-partner. The aim of the scheme is to allow someone to make an informed decision about whether or not they wish to be in a relationship if their partner has a history of violent or abusive behaviour. New guidance currently being consulted on by the Home Office proposes that the discretionary status of information sharing by the police is changed to a mandatory process. However, under the current scheme, which was in place in 2016 when John and Claire became partners, the police *have discretion to* decide to reveal information about previous convictions and cautions for violent or domestic-related offences.

Appendix 2: Discharge from mental health inpatient settings - GOV.UK (www.gov.uk)

Published 26 January 2024

- principle 1: individuals should be regarded as partners in their own care throughout the discharge process and their choice and autonomy should be respected
- principle 2: chosen carers should be involved in the discharge process as early as possible
- principle 3: discharge planning should start on admission or before, and should take place throughout the time the person is in hospital
- principle 4: health and local authority social care partners should support people to be discharged in a timely and safe way as soon as they are clinically ready to leave hospital
- principle 5: there should be ongoing communication between hospital teams and community services involved in onward care during the admission and post-discharge
- principle 6: information should be shared effectively across relevant health and care teams and organisations across the system to support the best outcomes for the person
- principle 7: local areas should build an infrastructure that supports safe and timely discharge, ensuring the right individualised support can be provided post-discharge
- principle 8: funding mechanisms for discharge should be agreed to achieve the best outcomes for people and their chosen carers and should align with existing statutory duties.

If an adult is detained under Section 3 Mental Health Act 1983, then Section 117 Mental Health Act also applies. This provides for discharge with free aftercare to support, if necessary, with health care, social care, employment services and

supported accommodation, if those services help reduce the risk of the adult's mental condition deteriorating. These duties do not apply if someone is detained under Section 2 Mental Health Act 1983 or is an informal patient. See Appendix 1 for further information on sectioning and eligibility under Section 117.

Detention under the Mental Health Act and Section 117 eligibility

If an adult remains in hospital after their Section 3 Mental Health Act expires then they are eligible to Section 117 when they leave. If, however, an adult is admitted to hospital under section 2 Mental Health Act, or informally (for example, voluntarily), the provisions of Section 117 do not apply. Thus, although being compulsorily detained under Section 3 of the MHA might appear to be the least desirable and least humane way of being admitted, an adult is likely to be afforded more support when discharged if they were forcibly admitted under Section 3 of the Mental Health Act.

Appendix 3: Effects of cocaine (see NHS)

Common effects of cocaine include:

- anxiety
- confidence
- dilated pupils
- energy
- euphoria
- increased heart rate
- paranoia
- restlessness

Long term effects of using cocaine

- Longer term effects of using cocaine can include:
- dependency
- damage to the heart
- mood swings
- poor sleeping patterns
- impotence
- malnutrition due to suppressed appetite
- difficulties manging your mental health which may affect mental health conditions
- damage to the lips, mouth and lungs caused by smoking cocaine
- needle-related injuries like infections and, in extreme cases, amputation of limbs

Appendix 4

Approaches for engagement include:

- **Building rapport** – taking time to get to know the person, being non-judgmental, not being shocked.

- **Flexibility** – be flexible about when and where to meet. The report Alcohol Change UK report, "Safeguarding Vulnerable Dependent Drinkers England and Wales (Ward and Preston-Shoot) states that, "*if a person is vulnerable, at risk of abuse and neglect (including self-neglect) or having a significant impact*

on the community, it is unhelpful, if not self-defeating, to require someone to leap a hurdle like attending an appointment with a stranger in a distant part of town. Assessment structures need to accommodate the difficulties faced by the client rather than be convenient for the worker. In particular, assessment should not be seen as a point in time, but rather as a process whereby services work with someone to enable an assessment to be undertaken. Without a process focus, services will fail the most challenging clients".

- **Do not discharge for non-attendance** - Other Safeguarding Adults Reviews (for example, the Thematic Review following the deaths of four women, West Sussex Safeguarding Adults Board, 2022; the Safeguarding Adults Review following the death of Adult D, London Borough of Camden, 2022; Mary and Graham, Leicester Safeguarding Adults Board, 2019) have identified the challenge faced by services when working with hard to engage, or "involuntary", clients. These reviews highlighted that services often waited for periods of stability or for a spontaneous change in engagement. Unfortunately, these opportunities rarely arose and instead, people who found it difficult to engage with services, to attend meetings or to comply with requirements were discharged from the services that might support them. The practice of discharge following missed appointments does not fit well with people who behave in a chaotic way because of their traumatic life experiences and is a factor that has been identified in other Safeguarding Adults Reviews and in published guidance.

- **Assertive outreach –** see Alcohol Change Assertive Outreach Handbook

- **Finding something that motivates the individual** – for example, linking to the person's interests. The Blue Light Project Manual (Alcohol Concern 2014), sets out alternative approaches that can be used, including motivational and harm reduction interventions built around assertive outreach and multi-agency working.

References

Bhandari, S. Singh, R. Sanya, M. and Dadhich. M. (2024) The impact of facial disfigurement and self-image anxiety on the quality of life of head and neck cancer patients. *Oral Oncology Reports*, https://doi.org/10.1016/j.oor.2024.100518.

Bradbury, E. Meeting the psychological needs of patients with facial disfigurement (2012). *British Journal of Oral Maxillofacial Surgery*. Apr;50(3):193-6. doi: 10.1016/j.bjoms.2010.11.022. Epub 2011 Mar 26. PMID: 21440966.

Bradbury-Jones, C., Taylor, J., Kroll, T. and Duncan, F. (2014). Domestic abuse awareness and recognition among primary healthcare professionals and abused women: A qualitative investigation. *Journal of Clinical Nursing*. 23, 3057-3068.

Choi, N. G., Kim, J. and Asseff, J. (2009) Self-neglect and neglect of vulnerable older adults: re-examination of etiology. *Journal of Gerontological Social Work*, 52(2), 171-187.

Degnan, A., Berry, K., Vaughan, M., Crossley, N. and Edge, D (2022). Engagement with services in Black African and Caribbean people with psychosis: The role of social networks, illness perceptions, internalized stigma, and perceived discrimination. *British Journal of Clinical Psychology,* 61(4), 1134-1153.

Fearon, P., Kirkbride, J. B. , Morgan, C. , Dazzan, P. , Morgan, K. , Lloyd, T. , Hutchinson, G. , Tarrant, J. , Fung, W. L. , Holloway, J. , Mallett, R. , Harrison, G. , Leff, J. , Jones, P. B. , Murray, R. M. and AESOP Study Group .(2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP Study. *Psychological Medicine*, 36(11), 1541–1550

Gibbons S, Lauder W, Ludwick R. Self-neglect: a proposed new NANDA diagnosis. *International Journal of Nursing Terminologies and Classifications*. 2006 Jan-Mar;17(1):10-8. doi: 10.1111/j.1744-618X.2006.00018.x. PMID: 16536733.

Greenfield P, Calcia M, McCree C, Sahota M, Thomas H, Kirkpatrick K, Vagi R, Howard LM, Markham S, Bhavsar V. Identifying, assessing and responding to perpetration of domestic abuse: practice guide for mental health professionals. *British Journal of Psychiatry Advances*. (2025) Jan;31(1):8-19. doi: 10.1192/bja.2024.39. PMID: 39959570; PMCID: PMC11826930.

Guyer, H., Ringeisen, H., Dever, J., Liao, D., Peytchev, A., Carr, C., Geiger, P., Stambaugh, L., Smith, T., Dixon, L., Olfson, M., First, M., Stroup, S., Chwastiak, L., Monroe-Devita, M., Swanson J, Swartz M, Kessler RC, Gibbons R, Bareis N, Sinclair Hancq, E., Clarke, T. and Edlund, M.(2024). The MDPS Consortium. Mental and Substance Use Disorders Prevalence Study: Background and Methods. *International Journal of Methods for Psychiatric Research*, 33(1):e2000. doi: 10.1002/mpr.2000. PMCID: PMC10803888

Hartung, F., Jamrozik, A., Rosen, M.E., Aguirre, G., Sarwer, D.B and Chatterjee, A. (2019) Behavioural and Neural Responses to Facial Disfigurement. *Scientific Reports* 9, 8021 https://doi.org/10.1038/s41598-019-44408-8

Keating, F. and Robertson, D. (2004). Fear, black people and mental illness: A vicious circle? *Health & Social Care in the Community*, 12(5), 439–447.

Kreyenbuhl, J. , Nossel, I. R. , & Dixon, L. B. (2009). Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. *Schizophrenia Bulletin*, 35(4), 696–703.

Lien C, Rosen T, Bloemen EM, Abrams RC, Pavlou M, Lachs MS. Narratives of Self-Neglect: Patterns of Traumatic Personal Experiences and Maladaptive Behaviors in Cognitively Intact Older Adults. *Journal of the American Geriatrics Society*, 2016 Nov;64(11):e195-e200. doi: 10.1111/jgs.14524. Epub 2016 Oct 14. PMID: 27739073; PMCID: PMC5118119.

Monckton-Smith, J. (2021) *In Control: Dangerous Relationships and how they end up in murder*. London: Bloomsbury

Morgan, C. , Fearon, P. , Lappin, J. M. , Heslin, M. , Donoghue, K. , Lomas, B. , Reininghaus, U. , Onyejiaka, A. , Croudace, T. , Jones, P. B. , Murray, R. M. ,

Doody, G. A. , and Dazzan, P. (2017). Ethnicity and long-term course and outcome of psychotic disorders in a UK sample: The AESOP-10 study. *British Journal of Psychiatry*, 211(2), 88–94.

Preston-Shoot, M. (2017) On self-neglect and safeguarding adult reviews: diminishing returns or adding value? *Journal of Adult Protection* 19(2) 53-66

Preston-Shoot, M. (2020), Safeguarding adult reviews: informing and enriching policy and practice on self-neglect. *The Journal of Adult Protect*ion 22(4), 199-215.

Rifkin, W.J., Kantar, R.S, Ali-Khan, S., Plana, N. M., Diaz-Siso, R., Tsakiris, M. and Rodriguez, E.D. (2018) Facial Disfigurement and Identity: A Review of the Literature and Implications for Facial Transplantation *AMA Journal of Ethics,* 20(4): 309-323. doi: 10.1001/journalofethics.2018.20.4.peer1-1804.

Sarwer, D.B., Siminoff, L.A., Gardiner, H.M. and Spitzer, J.C. (2022) The psychosocial burden of visible disfigurement following traumatic injury. *Frontiers in Psychology*, Aug 30;13:979574. doi: 10.3389/fpsyg.2022.979574. PMID: 36110275; PMCID: PMC9468754.

Stark, E. and Hester, M. (2019) Coercive Control: Update and Review. *Violence against Women*, 25(1), 81-104.

Trevillion, K., Oram, S., & Howard, L. M. (2013). Domestic violence and mental health. In L. M. Howard, G. Feder, & R. Agnew-Davies (Eds.), *Domestic violence and mental health* (pp. 18–28). RCPsych Publications.

Tsirigotis, K. and Luczak, J. (2018) Indirect self-destructiveness in women who experience domestic violence. *Psychiatric Quarterly*, 89, 521-532.

Ward, L., Ray, M. and Tanner, D. (2020). Understanding the Social Care Crisis in England Through Older People's Lived Experiences. In *Care Ethics, Democratic Citizenship and the State*. Urban, P. and Ward, L. (eds) Palgrave Macmillan: London.

Williams, K. and Steer, H. (2011). Illness perceptions: Are beliefs about mental health problems associated with self-perceptions of engagement in people with psychosis? *Behavioural and Cognitive Psychotherapy*, 39(2), 151–163.