BATH & NORTH EAST SOMERSET
COMMUNITY SAFETY AND SAFEGUARDING PARTNERSHIP

SAFEGUARDING ADULT REVIEW: Mr Martin Evans[1]

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Independent Overview Report Writers
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[1] Mr Evans's given name is used at the request of his family. This report refers to him as Martin.

1. OVERVIEW OF THE CIRCUMSTANCES THAT LED TO THIS REVIEW

1.1. Martin Evans was a White British man of 36 who died in March 2019. He had a long history of mental health concerns and alcohol use. He was found unresponsive at his home address but could not be resuscitated and was pronounced dead that the scene. The Coroner's inquest records the medical cause of death as 'unascertained' but concluded that he died as a result of the consumption of a benzodiazepine drug on a background of chronic liver disease due to alcohol.

1.2. Martin was alcohol dependent and in poor physical and mental health, with longstanding anxiety; he had liver damage and limited mobility. He also described himself to some practitioners as having a learning disability. He was regarded as a very high-risk drinker. He lived alone in a flat and concerns had been raised regarding self-neglect; he had very poor personal hygiene, his flat was unclean and he was not taking his medication. He wanted to move to a supported environment in which he could become alcohol-free. The absence of alcohol in his blood at time of death and the presence of an unknown benzodiazepine type drug make it possible that he was trying to detox himself[2].

1.3. He was known to a number of agencies, including Avon & Somerset Constabulary, Avon & Wiltshire Partnership for Mental Health Services, his GP surgery, South West Ambulance Trust, Royal United Hospitals and Virgin Care. He received services from multiple agencies including community matron, Guinness Partnership as his landlord, Developing Health & Independence and Drug & Alcohol Services. A multiagency risk management meeting (MARMM) took place in February 2019. The community matron and Drug & Alcohol Services had considered whether to make a safeguarding referral but were unsure whether he would meet the eligibility criteria.

1.4. Martin's father supported him with his finances and held his bank card, delivering money and alcohol to him and removing empty bottles when the council refused to do so due to the volume. Martin could become angry when drunk and between 2006 and 2016 had a history of assaults on others, including his mother, whom he also assaulted during the period under review.

2. BATH & NORTH-EAST SOMERSET COMMUNITY SAFETY AND SAFEGUARDING PARTNERSHIP'S DECISION TO CONDUCT A SAFEGUARDING ADULT REVIEW

2.1 The statutory duty

2.1.1. The B&NES Safeguarding Adults Board (SAB)[3] has a statutory duty[4] to arrange a Safeguarding Adults Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect (or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect) and

[2] A finding of the Drug-Related Death Review carried out by B&NES Council Public Health.
[3] Now part of the B&NES Community Safety and Safeguarding Partnership
[4] Sections 44(1)-(3), Care Act 2014

- There is reasonable cause for concern about how the SAB, its members or others worked together to safeguard the adult.

2.1.2. SAB partners must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[5]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.1.3. Avon & Somerset Constabulary completed a SAR referral relating to Martin on 20th August 2019. B&NES SAB undertook an initial discussion of the circumstances on 3rd September 2019, deciding to delay its decision on whether to conduct a SAR. On the information available at that time, the criteria for a mandatory SAR were not met, but the SAB[6] noted that a Drug Related Death Review [7] was in progress and that a Coroner's hearing was scheduled. On 14th January 2020 the Community Safety & Safeguarding Partnership's Practice Review Group (PRG) considered the outcome of the Coroner's inquest, held on 18th December 2019, and the Drug Related Death Review findings, which identified that there was potentially a lack of coordinated intervention and that the agencies involved may have missed opportunities to intervene. The PRG therefore requested preliminary information from agencies, on the basis of which, at a meeting on 7th February 2020, it concluded that the mandatory criteria for undertaking a SAR were met. This recommendation was agreed by the independent chair of the Community Safety & Safeguarding Partnership and this SAR was commissioned.

2.2. The SAR panel

2.2.1. A SAR Panel was appointed to undertake the review. Membership of the Panel comprised senior representatives of some of the agencies involved with Martin, together with a chair and lead reviewers who were independent of those agencies:

- Panel Chair
- Independent lead reviewers and overview report writers[8]
- Detective Inspector, Avon & Somerset Police
- Access Services Manager, Avon & Wiltshire Mental Health Partnership
- Deputy Safeguarding Lead, Bath & North-East Somerset Council
- Senior Regeneration Manager, Guinness Housing Partnership

[5] Section 44(5), Care Act 2014
[6] In September 2019, the Local Safeguarding Adult Board, the Local Safeguarding Children's Board and the Responsible Authorities Group merged to become the B&NES Community Safety and Safeguarding Partnership. The then 'SAR' subgroup of the SAB became the Practice Review Group.
[7] Undertaken by B&NES Council Public Health.
[8] Suzy Braye, Emerita Professor of Social Work, University of Sussex, and Michael Preston-Shoot, Emeritus Professor of Social Work, University of Bedfordshire, are independent adult safeguarding consultants experienced in reviewing serious cases. They also led the first national analysis of learning from SARs: Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for Sector Led Improvement*. London: Care & Health Improvement Programme. https://www.local.gov.uk/analysis-safeguarding-adult-reviews-april-2017-march-2019

- Adult Safeguarding Lead, Virgin Health Care
- Principal Social Worker, Virgin Social Care

2.2.2. The SAR Panel received administrative support from the B&NES Community Safety and Safeguarding Partnership Business Manager and the Partnership Administrator.

2.3. Terms of reference for the review

2.3.1. The time period under review was the year prior to Martin's death: 11th March 2018 to 11th March 2019. Agencies were also asked to summarise any involvement that fell outside this period and to identify any events or information they believed were significant.

2.3.2. The following key lines of enquiry were pursued:

a. Use of self-neglect and safeguarding policies and procedures;
    - To what extent do agencies understand the self-neglect policy and its application?
    - Did agencies choose to refer to adult social care rather than initiating the self-neglect policy?
    - Were all the relevant agencies and people involved in the self-neglect meetings and were the outcomes of these meetings shared with them in a timely way?
    - Were there earlier points at which the self-neglect policy could have been implemented, and if so, when?
    - Were safeguarding concerns followed up appropriately once the self-neglect policy had been enacted?
b. Timeliness of assessments and whether they identified and mitigated risks;
c. Assessment of mental capacity and executive functioning in the light of mental health concerns linked with alcohol/substance misuse;
d. Approaches taken to Martin's reluctance to engage with services and to give consent;
e. How family/carers were contacted and supported to care for Martin;
f. Effectiveness of interagency communication and collaboration and agencies' understanding of each other's roles;
g. Impact of learning from previous SARs in which self-neglect was a feature and the B&NES SAB conference to launch the self-neglect policy.

2.4. Other investigations/parallel processes

2.4.1. The Coroner's inquest was concluded prior to the commencement of the SAR.

2.4.2. The B&NES Council Public Health undertook a Drug Related Death Review, a summary of which was made available to the B&NES Community Safety & Safeguarding Partnership to assist its decision-making on whether to conduct a SAR. The summary has also informed the SAR.

3. THE REVIEW METHODOLOGY

3.1. The review model

The approach chosen was a review model underpinned by the principles set out in the Care Act 2014 statutory guidance (paragraph 14.167)[9]. It involved:

- Initial scoping of involvement by all agencies who provided services to Martin;
- Detailed chronologies of their involvement;
- Internal management reports (IMRs) prepared by the same agencies, reflecting on and evaluating their involvement;
- Thematic analysis of the learning themes emerging from the chronologies and IMRs;
- Discussions with Martin's family;
- Discussion with practitioners and operational managers who had been directly involved with Martin, with the purpose of seeking their perspectives on the events of the case, to ensure that the review's analysis and recommendations were informed by those most closely involved;
- Meetings of a SAR panel comprising relevant and nominated senior persons representative of the agencies involved;
- Formal reporting to the B&NES Community Safety and Safeguarding Partnership to inform its planning, implementation and monitoring of relevant actions across the partnership.

3.2. Agencies providing information to the review

The SAR panel received chronologies and, where necessary, additional information and/or documentation from the following:

Avon Fire & Rescue	Fire & Rescue were involved in Martin's situation twice: (i) On 10th January 2019 they received a referral from the South West Ambulance Trust identifying fire hazards in Martin's flat. An update on 14th February indicated that Martin did not want a visit and did not consent to information being shared. Fire & Rescue therefore did not attend the property; (ii) They were called on 16th February 2019 to assist ambulance crew at Martin's property.
Avon & Somerset Constabulary	The police had two contacts with Martin during the period under review: (i) From December 2018 they were investigating an alleged assault by Martin on his mother when drunk. Officers sought attendance at interview by Martin but when no contact could be made a decision was made to arrest him. He died before the arrest took place; (ii) Police attended his sudden death, finding his home in a state of squalor. His death was deemed non-suspicious, and the case was handed over to the Coroner for inquest.
Avon and Wiltshire Mental Health Partnership	AWP provides community and inpatient mental health services across Bath and North East Somerset, Bristol, North Somerset, Swindon and Wiltshire. The B&NES Hospital Liaison Team works within the Royal University Hospital to

[9] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

	provide advice, support, assessments and plans for anyone who has been identified with a mental health need requiring input from specialist mental health services. AWP's involvement was primarily through its Hospital Liaison Team while Martin was a hospital inpatient. The team carried out an assessment and liaised with the appropriate onward services that could help support Martin with his primary presenting alcohol issues. Shortly before he died, PCLS received a further referral, but despite numerous attempts to undertake an assessment Martin did not engage with them.
Developing Health and Independence	DHI provide drug and alcohol treatment in Bath & North East Somerset, in partnership with AWP, who deliver the medical aspects of drug/alcohol treatment and work with medically complex cases. We prepare people for a pharmacologically assisted detoxification and liaise with AWP for assessment around the detoxification and prescribing requirements. We provide brokerage and signposting to external agencies where we cannot provide support. DHI's support worker had known Martin for 4 years, the most recent involvement with starting in July 2018 and lasting until his death.
General Practitioner	The GP surgery provided general medical services to Martin and had numerous contacts with him as well as liaison with other agencies. His GP last had contact with him on 5th March 2019, by telephone.
Guinness Housing Partnership	Guinness Housing Partnership is a registered social landlord whose role is to provide housing related support in relation to income, housing management and tenancy sustainment. They were Martin's landlord. Since 9th June 2003 he had held an assured tenancy for a 1-bedroom general needs flat. During the period under review the Partnership had 24 interactions relating to Martin's tenancy, often with his father, who was his authorised contact. These interactions related to customer accounts, lettings and housing management enquiries, including monthly fire safety checks.
Royal United Hospital	Royal United Hospitals Bath NHS Foundation Trust (RUH) is commissioned by Clinical Commissioning Groups to provide acute health care in a hospital environment including mental health needs where there are physical care needs to be met. It is registered with the Care Quality Commission. During the period under review Martin was admitted to RUH twice ((i) 27th July-10th September 2018; (ii) 30th September-5th October 2018 for treatment of his deranged liver function and likely decompensated alcoholic liver disease and liver cirrhosis. He attended A&E on eleven occasions, related to his high levels of alcohol consumption and associated gastroenteritis, alcohol withdrawal symptoms, seeking medication or wanting to stop drinking. There was a pattern of him leaving before being assessed or self-discharging
South West Ambulance Service Foundation Trust	SWASFT had eleven face-to-face contacts with Martin during the period under review, and six telephone contacts. They completed six safeguarding referrals, which were shared with ASC and with the GP. Some were also shared with the Fire

	Service due to the level of risk to himself and others through his ongoing self-neglect.
Virgin Care – Health	Virgin Care is contracted to provide district nursing and community matron services. The community matron was supporting Martin's mother with her own needs and became a support to both his parents. She referred Martin to a community matron at his own surgery to ensure that he was reviewed in multidisciplinary team meetings. District nurses were involved in February 2019 when asked by the GP to take Martin's bloods.
Virgin Care – Social Care	Virgin Care (Social Care) hold statutory social care functions delegated from the local authority (subject to the exclusions set out in section 79(2), Care Act 2014). They support the local authority to carry out its statutory safeguarding functions. Virgin Social Care were involved with Martin from June 2018 onwards. He had an allocated social worker between September 2018 and February 2019, who then handed over to a new member of staff. His case was managed under the self-neglect policy from 4th February 2019.

3.3. Participation by Martin's family

3.3.1. Statutory guidance on the conduct of SARs [10] advises that the individual's family should be invited to contribute to the review. The B&NES Community Safety and Safeguarding Partnership Manager advised Martin's father and mother that the SAR was taking place, explaining the reasons for the review, its purpose and approach.

3.3.2. A telephone discussion took place between one of the independent reviewers (SB), the Partnership Manager, and Martin's father. Martin's father also submitted a set of notes detailing his contact with services between 1st January 2018 and his son's death. A subsequent telephone discussion took place between one of the independent reviewers (SB) and Martin's mother. Details from both conversations have informed the content of this report.

3.3.3. Towards the end of the review, the same independent reviewer spoke again by telephone separately with both Martin's parents to share with them the review findings and recommendations. Arising from these discussions, one further aspect of practice with their son – a query relating to his medication - was further explored before concluding the review. Both Martin's parents emphasised the need for all the learning from the review to inform future practice in the agencies involved, and for actions pursued in response to the report's recommendations to be closely monitored to ensure change takes place. Both also wished his full name to be used in the report, feeling this is an important mark of respect for him as an individual, honouring his life and the legacy of learning that it provides. Equally, they favoured publication of the full report as they wished the learning to be as widely available as possible.

[10] Department of Health & Social Care (2020) *Care and Support Statutory Guidance*. London: DHSC. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance Chapter 14 relates to safeguarding and contains guidance on SARs.

4. CASE CHRONOLOGY

This account has been created from the chronological information submitted to the SAR panel by participating agencies. Its purpose is to establish a clear narrative understanding of events as they unfolded over time.

Events prior to the SAR review period

4.1. Martin's father and mother gave accounts of their son's earlier life. Martin is one of two children in the family, having an older sister. He became ill in his early to mid-teens, becoming agoraphobic and refusing to attend school. He was known to Child and Adolescent Mental Health Services, receiving a diagnosis of schizophrenia and medication to treat mood and anxiety disorders. Martin's parents separated at around this time. As a young adult, Martin continued to receive mental health services and lived in several residential facilities for people with mental ill-health, although he was asked to leave due to his alcohol consumption. At 21, with the support of his social worker he moved into independent accommodation – a small flat in general needs housing, which he occupied until his death. Both his parents express concern about the quality of his housing and its impact on his mental health. They believe that he should have been in supported accommodation. He had no friends or social contacts, was overweight and had been drinking heavily for at least 10 years prior to his death. His father describes him as a child who never grew up emotionally.

4.2. Martin neglected his personal care, health, hygiene and domestic environment. He lived in squalid conditions and was deeply ashamed of the state of his flat and of his personal hygiene, for which he would apologise to practitioners. He has been described to this review as a gentle giant who, with the exception of times of anger and frustration, was polite and always grateful for help. He is said to have hated being a burden to his father.

4.3. Martin's father was closely involved in caring for his son consistently since the mid 1990s, liaising with services to seek their support for him and, in later years visiting him daily to undertake cleaning, shopping, laundry and management of finances and bills. He purchased alcohol for him, attempting to limit this to an amount that would prevent him having withdrawal symptoms. He describes his constant role in his son's life as a long journey. His diary expresses the emotional toll as well as the frustrations he experienced, and the despair of feeling that professionals treated his son just as "a drunk who doesn't want to stop drinking". He has had his own health concerns, being in recovery from cancer and also bereaved due to the loss of his subsequent partner in 2013. Three weeks before Martin died his father had withdrawn from seeing him, needing a break, although he continued to provide practical support. The death of his son has deeply affected him; he has sought support and is treated for depression by his GP.

4.4. Martin's mother too attempted to support her son. They did shopping together, and she attempted to teach him how to cook. Since his childhood he had been unable to eat in the presence of others, but he did attempt to make meals. When his father was ill his mother played a hands-on role in Martin's care.

4.5. Martin held his tenancy with the Guinness Partnership from 2003. The Partnership carried out a housing needs and general circumstances assessment at that time and subsequently had routine contacts with him (or with his father as Martin's authorised contact). They saw Martin himself during monthly fire safety checks in the building, and although noting that he valued his privacy and did not wish to converse at any length they had no cause for concern about him. In 2017 Martin requested a tenancy transfer, which was supported by his GP on grounds that housing-related issues were contributing to his stress and a relocation could improve his mental health. Guinness Partnership knew of his history of alcohol misuse but did not know of the seriousness of his situation until information was shared at the MARMM just a few weeks before Martin died.

4.6. The Police have records of 21 incidents involving Martin between 2006 and 2016. Nine relate to domestic abuse incidents against his mother (including 2 breaches of restraining order); seven relate to assaults on others, including 2 sexual assaults; four relate to him being a victim. None have been deemed of relevance to the terms of reference and focus of this SAR. He received 6 convictions and 2 cautions.

4.7. AWP's earliest documented contact with Martin was in October 2008, when he was being seen under the Recovery Team. He had been in contact with adult mental health services for the previous10 years and stated he was once told he was diagnosed with schizophrenia. He was discharged from secondary services in June 2010. In December 2010 he was seen by AWP's Liaison and Diversion Service having been charged with assault and breach of a restraining order against his mother. He spoke of hearing voices on a daily basis that told him not to do things, denying that they caused him any significant distress and reporting that he had got used to them and developed ways to ignore them. He experienced social anxiety, alcohol abuse/dependence, low mood/general anxiety and low self-esteem and reported historical overdoses taken with the intent to end his life but had not experienced suicidal ideation or thoughts to harm himself/others since 2007.

4.8. DHI had been involved with Martin for several periods of support and treatment: July 2010 – August 2011; October 2013 – May 2016; June 2014 – December 2014. The first of these ended with him having moderated his drinking to within safer levels. The following two episodes ended with him dropping out of treatment.

4.9. Prior to the period under review Martin had only one previous attendance at RUH; this was in 2015 for a fractured humerus.

4.10. Virgin Care (Social Care) records show a police report received in 2014 when Martin's mother disclosed that he had hit her. In 2017, the GP sent a referral to the Adult Safeguarding, Information and Signposting Team (ASIST)[11] and AWP's Primary Care Liaison Service (PCLS) to assess Martin's mental health. ASIST confirmed that PCLS would assess.

Events during the review period

4.11. On 14th June 2018 Martin's landlord, Guinness Partnership, logged a concern about rubbish in the communal area of the property. They wrote to all residents in the building. There was no evidence to link the rubbish to Martin's flat.

[11] ASIST is now known as the Virgin Care Adult Safeguarding Team

4.12. On 15th June 2018, Martin's GP undertook a joint visit to Martin with the Community Matron. Martin's father was also present. Martin was sober, coherent and clear in his thinking. He was embarrassed at the state of his flat, which was in squalor, and recognised he was in poor health but refused hospital admission. He was assessed as having capacity to make that decision. The GP agreed to alert AWP's Primary Care Liaison Service, which he did the same day, and the community matron was to make a safeguarding referral.

4.13. On 18th June 2018 the community matron raised a safeguarding concern with Virgin Care (Social Care) ASIST. Following discussion, it was concluded that the situation appeared to be about 'carer breakdown' and longstanding issues relating to Martin's mental health and alcohol use. Martin was therefore to be referred to mental health services and supported via care management.

4.14. During June and July 2018, the community matron carried out baseline observations on three occasions.

4.15. Martin, newly referred back to DHI, was assessed by DHI at home on 25th July 2018 in the presence of the community matron and Martin's father. He was assessed as a very high-risk drinker and was referred to AWP's Specialist Drug and Alcohol Service (SDAS) for assessment, as he required a high level of clinical oversight during detoxification.

4.16. On 27th July 2018 the GP informed Martin's father that Martin's blood test results showed significant liver damage. He was admitted to RUH and diagnosed with alcoholic cirrhosis of the liver. He underwent detoxification in hospital, with regular visits from DHI and SDAS, who referred him to the social work team. At the same time, on 31st July 2018 RUH referred Martin to the AWP's Hospital Liaison Team. Their assessment on 5th August 2018 identified no acute mental health need requiring input from secondary mental health services and a recommendation for residential detox. A referral was made to Burlington Street rehabilitation house but they were unable to accept him due to his high medication and support needs.

4.17. On 15th August 2018, while in hospital Martin was assessed as having mental capacity to make decisions about his health.

4.18. On 31st August 2018, Martin's father contacted Guinness Partnership to enquire as to progress on his son's request for a tenancy transfer.

4.19. On 8th September 2018 the Police investigated a concern from Martin's neighbour, passed to them by the Guinness Partnership, that she hadn't seen Martin for some weeks. Martin was confirmed as an in-patient at RUH and the Police advised the Guinness Partnership.

4.20. The hospital social work team arranged a deep clean on his flat, undertaken by WeCare & Repair on 10th September. They advised DHI that they should refer Martin for a care and support needs assessment when Martin was at home in his own environment.

4.21. Martin was discharged from hospital on 11th September 2018. Despite 7 weeks in hospital and the detox he returned to drinking the same day.

4.22. On 12th September 2018 DHI referred him to Virgin Care for a care and support needs assessment at home. He was also referred to AWP's Primary Care Liaison Service (PCLS) for review of his mental state and medication. Following five unsuccessful attempts to contact him PCLS discharged him back to his GP on 26th September 2018.

4.23. On 14th September 2018, Martin's father advised the Guinness Partnership that Martin had been in hospital and that the property had been deep cleaned and restored to a satisfactory condition. A property inspection was scheduled but there is no record that one took place. Guinness Partnership records also contain reference to the GP to be contacted for support but there is nothing to suggest that this took place.

4.24. On 20th September 2018 Martin requested medication from the GP surgery as he was experiencing withdrawal symptoms and panic attacks. Having already issued prescriptions the surgery arranged a dossette box.

4.25. On 30th September 2018 Martin was readmitted to hospital by ambulance, having started to drink again and failing to take his medication. RUH again referred him to AWP's MHLT. It was agreed, however, that he was not presenting acute mental health need and his care should be pursued through DHI and Adult Social Care. Martin's father raised concerns with the surgery about plans to discharge him again without support. He was discharged on 5th October 2018.

4.26. On 10th October 2018 the community matron discussed Martin's self-neglect with him and his father and secured his agreement to activating a multi-agency risk management meeting (MARMM). On 30th October the community matron offered to refer Martin to mental health services but he refused consent to this referral.

4.27. On 1st November DHI and a social worker from Virgin Care conducted a home visit to attempt an assessment but Martin was either not there or did not answer the door. The following day Martin told his GP that he had stopped drinking and recognised the benefit he gained from doing so. He wanted to do voluntary work and was referred to My Script[12].

4.28. A week later Martin was telling DHI he had stopped drinking for the past 7 weeks and that he felt much better. He said that physically he was much improved and that he wanted to continue attending support groups to maintain his sobriety.

4.29. A further planned joint visit between the social worker and DHI did not take place as DHI did not attend and the social worker was bound by risk guidance requiring no lone visits. It was later clarified that the DHI worker was temporarily unavailable.

[12] MyScript is a service run by DHI, which aims to help people with issues that they might present to their GP, but which are not necessarily something a doctor is best placed to help with.

4.30. On 19th December 2018 Martin visited his mother's home while drunk and assaulted her. The Police completed DASH[13] and BRAG[14] assessments, resulting in medium and amber[15] risk evaluations respectively, and placed a Treat as Urgent marker on the address. They made a Lighthouse Safeguarding Unit[16] referral, with onward referral to B&NES ASC. A MARAC referral did not progress to multiagency discussion. There is no record of his mother taking up any support and she did not wish to prosecute. The police attempted to interview Martin over subsequent weeks, liaising with mental health and social care teams, and on 9th March a decision was made that he should be arrested for interview. Martin died before he could be interviewed.

4.31. On 20th December 2018 Martin rang the Virgin Care (Social Care) social worker in response to her letter and requested an assessment. The social worker recorded a 'Conversation 1' for the period between 10th October to 20th December 2018. This records a chronology of the attempted contacts between the social worker, DHI and Martin, and an outcome for a 'Conversation 3' - a care and support needs assessment - to be completed. No care and support needs assessment was undertaken before Martin's death.

4.32. Also on 20th December 2018 Virgin Care referred Martin to AWP due to concerns about his mental health. The social work checked in early January that the referral was in progress. AWP attempts to engage Martin, however, were unsuccessful and they discharged him back to his GP on 24th January 2019.

4.33. On 10th January 2019 Fire & Rescue Service received a referral from the Ambulance Service for a home fire safety visit, but before a visit was scheduled a note was added to indicate that Martin did not want a visit and did not consent to information being shared. The referral was therefore closed on 14th February 2019 on the grounds that the occupant had declined the visit.

4.34. On 16th January 2019 DHI and the Virgin Care social worker made a further joint visit. By this time Martin had returned to drinking 40 units daily and his living situation had declined, as had his mental health. He told them that he needed some type of supported accommodation. The outcome of the assessment was that Martin was unlikely to meet the threshold for safeguarding action but that he was eligible for further support from Adult Social Care.

4.35. Martin subsequently continued to contact DHI, telling them that things were getting worse and he was worried.

[13] DASH is a nationally implemented tool for identifying, assessing and managing risk arising from domestic abuse, stalking and harassment, and honour-based violence. It enables officers to assess level of risk of serious harm for the victim to support safeguarding.
[14] BRAG is a vulnerability assessment tool introduced in 2018 to help safeguard vulnerable people. It helps officers assess vulnerability and risk more objectively and use this assessment as a way to determine what action should be taken.
[15] An amber rating refers to there being no immediate risk requiring immediate safeguarding, but that may be a risk of significant harm if the activity/concern continues.
[16] The Lighthouse Safeguarding Unit, launched September 2018, supports victims and witnesses of crime alongside safeguarding overview. It provides a streamlined approach to supporting individuals through improved ways of working with partners.

4.36. During January 2019, Martin called SWASFT on 4 consecutive days. He was very anxious, had been vomiting blood and had rectal bleeding. He was taken to hospital but discharged the same day. On subsequent days he reported feeling very anxious; he was drinking up to 10 litres of cider a day but was apologetic on each occasion about the state of his flat. He cited lack of a job, untidy living space, reduced liver function and ongoing mental health issues all adding to his anxiety. He wanted housing support and wanted to stop drinking.

4.37. On 24th January 2019 the GP surgery noted that Martin was requesting his medication a day early each week. An appointment was made to discuss this, but he did not attend.

4.38. By the end of January 2019, Martin was experiencing liver pain but had not seen his GP, saying 'they don't do anything'. He had demanded to be taken to RUH three times that month and had been unusually aggressive towards ambulance crew. The crew spoke with him about his alcoholism and suggested that a safeguarding referral might help to get his flat cleared and help with his drinking, with which he agreed. The crew also noted that his fire alarm was taped up but he refused a referral to the fire service, although one was made anyway in the public interest.

4.39. DHI completed another home visit on 30th January 2019, noting that his physical and mental health had deteriorated further. They agreed to explore detox options and arrange another multidisciplinary team meeting with Adult Social Care, Guinness Partnership and the GP.

4.40. During January 2019 the social worker was in active communications with other agencies and with Martin's father. From 4th February Martin's case was managed under the self-neglect policy and a risk management meeting was planned.

4.41. On 5th February 2019 the GP notified PCLS that Martin was still mentally unwell and that he should not be discharged from their service due to his non-response to a letter. They were requested to make further efforts to engage him. PCLS advised the surgery that they did not operate as a crisis service and would not call without an agreed appointment. In the absence of Martin's engagement there was nothing more they could do, other than arrange a Mental Health Act assessment.

4.42. On the 6th of February Martin was admitted to the RUH but self-discharged before any discharge plan could be developed. His father again requested the surgery's support to secure admission. The GP referred him to the community matron.

4.43. On 11th February 2019 Martin's father called SWASFT for a welfare check as he had not heard from his son. The crew found Martin sitting in his chair surrounded by bottles and cigarette ends. He was now admitting to smoking 60-80 cigarettes a day and drinking 10-15 litres of cider a day. Ambulance crew contacted the GP, who also spoke to Martin's father, and arranged blood tests through the district nurse. The ambulance crew made a safeguarding referral.

4.44. On 13th February Adult Social Care chaired a multiagency MARMM, attended by representatives from the Guinness Partnership, DHI, Adult Social Care and the

community matron. AWP was not present but has no record of having received an invitation. RUH appear not to have been invited. It was noted that Martin was not suitable for community detox due to his poor physical health. DHI agreed to arrange a further home visit with a consultant psychiatrist from SDAS to assess for detox. Adult Social Care agreed to undertake a Care Act assessment and a deep clean was to be arranged. The community matron would be taking bloods to ascertain whether hospital admission was necessary. It was queried whether an authorisation under DoLS would be required to prevent self-discharge at some future point.

4.45. The following day the social worker contacted a specialist support and supported accommodation provider for those living with alcohol-related brain damage to query whether they would consider Martin. The provider advised they could provide short-term accommodation but the person must undergo detox before moving to the home.

4.46. On 14th February 2019 a health care assistant from the GP surgery who had taken bloods on a home visit raised concerns with the GP about the state of Martin's flat and his self-neglect. The GP spoke to the social worker to ensure they were aware. Advice was taken from the RUH consultant about whether the blood results warranted hospital admission. The following day the GP requested that SWASFT convey Martin to hospital. Due to demand, Martin had to wait 13 hours for ambulance transport. Martin was admitted via A&E, but self-discharged after a few hours.

4.47. On 16th February the Fire & Rescue Service attended at the request of the Ambulance Service to assist them in gaining access to Martin's address.

4.48. We Care & Repair undertook a deep clean assessment on 20th February, with the clean itself booked for the following week. Martin's father was willing to look after Martin away from the property so that it could take place. By the due date, however, he had withdrawn from supporting Martin in any other than financial terms, so the clean was cancelled. It was to be rescheduled but did not take place before Martin's death.

4.49. On 21st February the Virgin Care social worker, who was leaving her post, did a joint visit to Martin with another social worker who was replacing her.

4.50. Martin's father continued to express concern to the GP, the social worker and SWASFT; his son had now become incontinent and was not eating. On 22nd February Martin called SWASFT himself; he was unwell with gastroenteritis, pale, confused, dazed, shaky and having blackouts. He was very anxious and was taken to hospital but discharged himself. He attended A&E again on both 23rd and 25th February, with the same outcome.

4.51. On 26th February 2019 the urgent treatment centre informed AWP that Martin had been presenting unwell. AWP advised attendance at RUH to check on physical health due to possible alcohol withdrawal. The RUH rang the GP to confirm that Martin had attended A&E and didn't appear to be ill but had mental health issues. They requested an urgent GP appointment.

4.52. On 1st March 2019 DHI advised the social worker that a planned visit to Martin at home with the consultant psychiatrist had had to be postponed due to the

conditions in the flat. A further visit was scheduled for 12th March to discuss treatment options, including the possibility of detox while in the community.

4.53. On 5th March 2019 Martin's father rang the social worker and his mother rang the GP surgery to advice that their son had continual diarrhoea and vomiting due to alcohol and was very unwell. The GP spoke to Martin on the phone to arrange a visit; he was very intoxicated and already at A&E.

4.54. On 7th March 2019 the social worker informed the GP that they could not undertake an assessment at Martin's home due to the unhygienic state of the premises. They were liaising with DHI to arrange for Martin to go to bed & breakfast accommodation, to which he had agreed, so that a deep clean could take place.

4.55. Martin was found deceased at his home on 11th March 2019, by his father, who called the emergency services. He had last dropped money off to Martin two days previously – the money was still in the letter box. The ambulance service and the Police attended. The Police followed their standard sudden death procedure, found no suspicious circumstances and passed the case to the Coroner. In the days following his death they received distressed calls from his mother, whom they signposted to the Coroner.

5. THEMED ANALYSIS

This section of the report addresses the learning themes arising from the SAR panel's integrated analysis of the information submitted by agencies and the perspectives of practitioners and managers who attended the learning event. It sets out learning relating to the key lines of enquiry, structuring these into three domains: (A) direct practice with Martin; (B) interagency communication and coordination; (C) organisational features within the agencies involved.

DOMAIN A: Direct work with Martin

5.1. Timeliness of assessments and whether risks were identified and mitigated

5.1.1. The evidence-base for best practice in cases of self-neglect[17] emphasises the importance of thorough and regularly reviewed assessments, including of risk. Comprehensive risk assessments are advised, especially in situations of service refusal and/or non-engagement, using recognised indicators to focus work on prevention and mitigation. [18] Assessments, care plans and regular reviews should comprise comprehensive enquiries into a person's rehabilitation, resettlement and support needs [19] , taking into account the

[17] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21(4), 219-234.
[18] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15(1), 15-25. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual*. London: Alcohol Concern.
[19] Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

negative effect of social isolation and housing status on wellbeing[20]. It is helpful to build up a picture of the person's history, and to address this "backstory"[21], which may include recognition of, and work to address, issues of loss and trauma in a person's life experience, which can underlie refusals to engage or can manifest themselves in repetitive patterns.

5.1.2. Administrative law standards[22] require practice to be timely, considering all relevant information drawn from wide consultation, with decision-making that is reasonable and rational and clearly explained in records.

5.1.3. The Virgin Social Care contribution to the review recognises that available records do not give a good sense of who Martin was. It is not clear whether this information was not recorded or was never sought. To comply with the principle of making safeguarding personal, strongly foregrounded in statutory guidance[23], a stronger sense should have emerged of who Martin was, what his hopes were, his aspirations, abilities and desired outcomes.

5.1.4. Virgin Social Care's contribution observes that there were multiple conversations with practitioners and Martin about his needs, but a care and support assessment was not completed. There is reference in the MARMM minutes to a plan for the social worker and her manager to visit Martin to discuss a care and support assessment on 17th February 2019. It should have been completed within 28 days.

5.1.5. When Martin was referred for a home fire safety visit, AFRS did not meet its target response time of 2 weeks. There is no evidence that contact was attempted during that time. AFRS has found inconsistencies in the recording of home fire safety visits, particularly when duplicate referrals are received. All should be separately logged. The home fire safety visit process has been reviewed to identify improvements, including booking systems to ensure internal targets are met.

5.1.6. On risk assessment specifically, DHI's submission to the review acknowledges that its risk assessment could have been more comprehensive. It should not be assumed that the existence of a SAB endorsed multiagency self-neglect policy and procedure will obviate the need for comprehensive single agency risk assessments as a contribution to a multiagency safeguarding effort. Virgin Social Care's contribution includes recognition that consideration should have been given to risk in response to an accumulation of referrals and concerns.

5.1.7. While Martin was an in-patient in RUH, AWP practitioners graded his overall risk level as medium. This rating appears to comprise different ratings in

[20] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.
[21] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.
[22] Preston-Shoot, M. (2019) *Making Good Decisions: Law for Social Work Practice* (2nd ed). London: Red Globe Press/Macmillan.
[23] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

relation to different aspects of his situation. Risk was rated as low while he remained in hospital, given his removal from his flat, his detox and his care needs being fully met. However, risk in terms of harm to self was rated as high, given the concerns of significant self-neglect at home. Martin's flat was uninhabitable due to his alcohol dependence; his father was visiting daily to wash clothes and clean up faecal incontinence. Risk of reoccurrence of relapse of alcohol use was also rated as high without adequate discharge and ongoing coordinated planning. A crisis intervention plan was not completed. Martin was referred for social work and residential detox.

5.1.8. Virgin Social Care's contribution acknowledges the need for improvements with respect to risk assessment and analysis, care and support assessments, and the quality of recording. They did not have a generic risk assessment document for social care at the time. Virgin Care has now adopted a self-neglect register, recording risk RAG ratings and MARMMs, and providing regular reports of reviews of people on the register to Virgin Care Quality and Safety.

5.1.9. In conclusion, risks were assessed by different services involved as high but there was no completed care and support assessment and no crisis intervention plan. Not all agencies had a risk assessment template at the time.

5.1.10. The evidence-base for good practice in self-neglect also emphasises the importance of thorough assessments of mental health. This is especially the case when mental distress is present alongside substance misuse. Several learning points emerge through an analysis of this case.

5.1.11. First, his mental health diagnosis varied over time. GP records contain a diagnosis of mixed anxiety and depressive disorder (2005) and one of unspecified affective psychosis (1999). DHI have a diagnosis of schizophrenia (provided by Martin himself but also logged by AWP in 2017, along with social phobia). Also mentioned (by Virgin Care and elsewhere) are paranoia and anxiety, low mood and depression, and agoraphobia. Martin himself also told SWASFT that he had learning disability, Asperger's and autism, although no agency has any record of a diagnosis of learning disability. Formal diagnoses revolved around mental health, with references also to disabilities – emotional/behavioural, mobility and manual dexterity. Other SARs [24] have highlighted the importance of accurate, shared diagnoses and the impact that uncertainty or disagreement can have on practice responses.

5.1.12. Second, Martin's mental health issues were longstanding, dating back to childhood. AWP electronic records date back to 2008. Staff would have been able to go back through all prior assessments and information that was held. As part of AWP's assessment process, it would be expected that prior notes and risk assessments would be consulted to help with formulation of the current situation. There are brief mentions in the AWP assessments of Martin reporting that he had experienced mental health issues since the age of 13. However, AWP advise that, unless there was an issue being presented that required the service to go back that far, it would not routinely request

[24] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.

information from childhood [25] . It has been suggested that assessments of Martin had sufficiently detailed information to enable formulation of appropriate plans. However, there was no evidence that a trauma-informed approach was considered in this case and no apparent recognition that adverse experiences, including from childhood, can impact significantly on emotional wellbeing in adulthood. SARs involving self-neglect[26] consistently make this point.

5.1.13. Third, Martin was assessed as not meeting the threshold for secondary mental health services. One result of this assessment was that mental health services did not contribute to a support and intervention package for when Martin was discharged from hospital[27]. Nor were PCLS present at the MARMM (they have no record of having received an invitation). This review has been advised that that threshold for secondary mental health services relies on an evaluation of combined need and complexity. If Martin's situation did not meet this threshold, this raises important questions about how practitioners can access mental health support for individuals who are not in acute need or experiencing an acute psychotic episode but whose needs are acknowledged as complex and risks are high. The GP surgery in particular has noted difficulty accessing mental health support for patients if secondary services decline.

5.1.14. Related to this is a question about how mental health social work services are accessed. Mental health social workers, who are responsible for carrying out the local authority's Care Act 2014 duties in respect of people with mental health needs, are located within AWP. If an individual does not meet the threshold for secondary mental health service from AWP, their needs for care and support services do not come to the attention of mental health social work, potentially leaving a gap in the local authority's fulfilment of its statutory responsibility.

5.1.15. The fourth issue is how the relationship between mental health and alcohol abuse was understood. All agencies were well aware of his alcohol use. Some agencies saw it as self-medicating to relieve anxiety. Others saw his anxiety as arising from his alcohol use. The social worker was advised by AWP around the time of the MARMM that his anxiety was caused by drinking. So, there were different perceptions of what the primary problem was. What was missing in this case was a coordinated plan to address both mental distress and alcohol abuse.

5.1.16. Instead, SDAS had hardly any involvement with Martin: just 2 assessments in 2014 and 2017. Just before he died an SDAS doctor was due to accompany another professional from DHI to do a home visit and assessment, but this was postponed due to conditions in the flat and did not take place before Martin died. Martin had a lot of involvement with DHI for support around reducing and stopping his alcohol consumption. However, Martin was not open to mental health services after 2010. He had contacts with CARS in 2012 and 2014 as part of criminal investigations (which resulted in non-conviction) and

[25] AWP's contribution to the review advises that there are regularly meetings between CAMHS and Adult Mental Health Services (AMHS) at which a smooth transfer of cases can be organised. Information is sought and obtained from CAMHS when someone is referred as an adult and has not previously been considered during transition from CAMHS to AMHS.
[26] For example, see Preston-Shoot, M. (2020) *Thematic Review – Ms H and Ms I*. Tower Hamlets SAB.
[27] DHI submission to the review.

occasional contacts with PCLS in 2012/2014/2015/2017. These contacts usually concluded that neither admission to mental health hospital nor entry into secondary mental health services were indicated. The main issue identified was alcohol abuse. He was given information on several occasions about self-referral to agencies offering psychological therapy, but he did not follow through on this option and no professional curiosity appears to have been expressed about this.

5.1.17. In September 2017 an appointment with PCLS concluded with diagnoses of alcohol dependence, schizophrenia and social phobia. The plan was to request an opinion of the Consultant Psychiatrist in SDAS due to alcohol dependence predominating as a problem but with uncertainty about how this might affect his other difficulties, not least because Martin was ambivalent regarding change. Put another way, it was unclear how much of his social decline was attributable to alcohol and how much to possible negative features of illness. The plan recognised that, should Martin want to take up detox and then rehabilitation, the placement for the latter would need to be mindful of his mental health difficulties. Nonetheless, a coordinated approach to managing his mental health difficulties and alcohol abuse does not appear to have materialised.

5.1.18. AWP have told the review that, with regards to their engagement with Martin, contracted and agreed processes were followed, including standard operating procedures for both PCLS and MHLT. AWP noted good practice in that the MHLT maintained contact and oversight of Martin's case while he was an in-patient in the RUH. The Mental Health Coordinator ensured that a referral to PCLS was made. AWP have also reflected that there could have been more assertive follow up to Martin's non-engagement with PCLS (although AWP maintain there was no information to suggest this was necessary) and also made a joint visit with Virgin Care at an earlier stage.

5.1.19. One prompt for review of assessment, planning and decision-making should be the evidence of repeating patterns. Repeating patterns were evident in this case but they did not prompt reappraisal of the approach being taken. There were repetitive telephone contacts and callouts of SWASFT, six of which resulted in safeguarding referrals. There were two inpatient episodes at RUH and 11 presentations at the Emergency Department between 6th January and 5th March 2019, with some instances where he self-discharged. Martin's attempts to remain alcohol-free after detoxification were unsuccessful and he relapsed. He was unable to maintain a habitable living environment. Some services found it difficult to engage with Martin; for example, he missed some appointments with PCLS and was discharged back to the care of his GP.

5.1.20. Both RUH and SWASFT have advised that there are systems for tacking high intensity users. However, the RUH system is dependent on practitioners recording the number of attendances. For self-discharges, there is no tracking mechanisms, meaning that staff have to look back in hospital records. There is a regular High Impact Meeting and it had been suggested that Martin should be discussed there. However, he died before this could happen. Similarly, SWASFT employs a system for monitoring "frequent flyers" but Martin's usage of the Ambulance Service would have been insufficient to trigger this mechanism. Apparently, the number of calls he made is unremarkable in terms of demands on that service.

5.2. Responses to reluctance to engage

5.2.1. The evidence-base for best practice in self-neglect foregrounds best practice relating to engagement. A person-centred approach is recommended that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes. Work should try to build motivation, with a focus on a person's fluctuating and conflicting hopes, fears and beliefs, and the barriers to change.[28] A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills; early and sustained intervention includes supporting people to engage with services, assertive outreach and maximising the opportunities that an encounter brings.[29] When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; failing to explore "choices" prevents deeper analysis.[30]

5.2.2. Martin engaged with his GP and with acute healthcare practitioners in RUH. A Community Matron for Martin's parents also built a relationship with Martin and remained involved. Some services clearly found engagement a challenge but adopted a flexible approach in response. DHI, for example, undertook home visits, a departure from that service's usual practice that has been determined by staffing capacity. This is good practice. Some of these visits, however, had to be cut short when his flat was an unsafe space in which to practise. Also good practice was the persistence was also shown by a social worker who acknowledged Martin's embarrassment at the condition of his property, which may have acted as a barrier to his working with some services and practitioners.

5.2.3. Overall, Martin does not appear to have engaged routinely with PCLS and there is no indication that missed appointments prompted a consideration of the need for assertive outreach. Virgin Care have reported that on one occasion a social worker had a conversation with the PCLS practitioner and PCLS attempted a telephone consultation. Martin answered but was not at home and advised the practitioner that he would prefer a call back. When he was called back he did not answer. PCLS sent Martin a 7-day opt-in letter. On reflection, this may not have been the best way for PCLS to try to engage with Martin or, indeed, other adults who self-neglect. However, Virgin Care also did not challenge this at the time.

[28] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual*. London: Alcohol Concern. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[29] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.
Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual*. London: Alcohol Concern.

[30] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.

5.2.4. Virgin Care have reflected that, given Martin's embarrassment around his environment, consideration could have been given to the location where practitioners met him. A different environment may have improved engagement as records indicated that he was quite distracted by his feelings of embarrassment and possibly shame in relation to his living environment. Whilst it is important to assess the environment, there is also value in building a trusting relationship with the person that enables the environment to be addressed. In similar situations, this could help a person engage.

5.2.5. Other contributions to the review have also reflected on engagement. For example, GPs have reflected that better continuity of care might have been established if only one or two doctors had been involved. SWASFT have commented on inflexibility in systems resulting in a failure to recognise that getting to appointments may prove too great a physical task for some individuals. Other SARs[31] have also pointed this out.

5.2.6. AWP have commented that their systems are flexible but that there were no indications from other services more intensive follow up was required when he did not respond. The volume of referrals AWP receives does require processes in place to deal with non-engagement. However, there will be occasions when assertive outreach should be considered as part of a coordinated multi-agency approach. That requires recognition of situations when a multi-agency review is prompted by a practitioner and/or service saying: 'enough is enough', 'there must be something more that we can do.' That is a form of escalation but neither practitioners nor senior managers escalated concerns about this case. As a result, despite Martin's very pressing and significant needs, and despite the risks of significant harm, he was to at least some degree left to manage on his own.

5.3. Assessment of mental capacity and executive functioning in the light of mental health concerns linked with alcohol/substance misuse

5.3.1. The evidence-base for best practice in self-neglect advises thorough mental capacity assessments, which include consideration of executive capacity; assumptions should not be made about people's capacity to be in control of their own care and support.[32]

5.3.2. Services have been candid in recognising shortfalls in this practice arena. Virgin Social Care have not found any record to indicate that consideration was given to the influence of alcohol on Martin's capacity and his executive functioning does not appear to have been considered at any point. Virgin Care have concluded that better documentation is needed on the outcomes of mental capacity assessments, with reasons given for decisions. DHI's contribution to the review includes awareness of the impact drugs and alcohol have on capacity and the ability to execute decisions made. That said DHI were unable to find any record of discussions or decisions made around capacity. The service has concluded that more training and regular refreshers around

[31] For example, see Preston-Shoot, M. (2019) Safeguarding Adults Review – Andy. Salford Safeguarding Adults Board.

[32] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

the Mental Capacity Act and its use in their context are required, including being a core requirement for all team leaders.

5.3.3. SWASFT completed seven mental capacity assessments in January and February 2019. Recently, training has focused on the impact of alcohol abuse on mental capacity, for example when patients decline treatment and/or conveyance to hospital. RUH have observed that there was a high frequency of attendance at ED February 2019 and incidents of Martin self-discharging without a capacity assessment being completed each time. Work has already taken place on reviewing the self-discharge form. Good practice was that staff did undertake capacity assessments on some occasions. Where the RUH could have improved practice would be recording Martin's capacity to make the decision to self-discharge at every opportunity. The self-discharge form has subsequently been amended to record that capacity has been assessed or that the professional opinion of the member of staff countersigning the form is that the patient had capacity to take their own discharge against medical advice.

5.3.4. One crucial opportunity to review Martin's mental capacity and to plan assessments was the one Multi-Agency Risk Management Meeting that was held. It would appear that this opportunity was missed. The DHI contribution to the review has suggested that those staff attending the meeting were unsure what to do next. There were conversations around whether Martin had capacity to make decisions in relation to his physical health and specifically to understand why his health was deteriorating and the role alcohol played in this decline. As far as the DHI practitioner could recall, there was no assessment of capacity made or planned. Virgin Care Health's contribution here has been informed by the Community Matron who attended the MARMM. Her recall is of Martin discharging himself from RUH. The situation was deemed very challenging to all involved. At the time of the meeting, he was at home, when he would often be intoxicated, ruling out an assessment at that time. She confirms that the meeting did consider whether, when he was next in hospital, Deprivation of Liberty Safeguards could be used, acknowledging that Martin had struggled with mental illness all his life and that he found it difficult to cope in a hospital environment. It is possible there was a misunderstanding at the meeting of whether mental capacity or mental health legislation would have been more appropriate here.

5.3.5. In summary, there was an over-reliance on the presumption of capacity. There are references to missed opportunities to assess, mainly when he self-discharged but also at the one MARMM. There are references to "no reason to doubt." There are references to records being silent on whether mental capacity was considered, including at the one MARMM, despite mention of the possible need to consider Deprivation of Liberty Safeguards. There was a failure to take account of alcohol dependency and possible impairment of executive function on his mental capacity. There appears to have been no consideration of referral to the Court of Protection.

5.3.6. With regard to executive function, this review has identified that neither NHS England's MCA prompt cards (which are widely shared with primary care providers by Bath & North-East Somerset, Swindon and Wiltshire CCG) nor the RCGP guidance on mental capacity mentions the significance of executive function. While the NICE guidance (which does discuss approaches to capacity assessment in cases of potential executive dysfunction) is made available on

the CCG website, the CCG have reflected that staff may well not use it as a first port of call for guidance on mental capacity assessment and that the significance of executive function needs to be further highlighted in guidance given to staff.

5.4. Work with Martin's family

5.4.1. GP Surgery notes record frequent communication with Martin and his family. RUH staff also had contact with Martin's father and were responsive to issues he raised; a deep clean of Martin's flat was undertaken, for example, following concerns his father expressed to the hospital. Virgin Care records also contain evidence of frequent interactions with Martin's father. The community matron from Martin's parents' surgery was closely involved in supporting Martin's father. Aware of the stress he was under, she encouraged him to seek support for himself, offering to make referrals, but he declined these offers.

5.4.2. Martin's social worker did maintain communication with Martin's father. However, there is no record that a carer's assessment was either considered or offered. This is an omission.

5.4.3. The evidence-base for best practice in self-neglect recommends, where possible, involvement of family and friends in assessments and care planning[33] but also, where appropriate, exploration of family dynamics, including the cared-for and care-giver relationship. That would have been indicated in this case since there were concerns about whether his father's involvement increased Martin's dependence and whether his parents had deskilled and undermined him[34] . At the learning event there was reflection on whether practitioners should have taken steps to secure advocacy for Martin, in order to reduce his reliance on his father to make decisions on his behalf (for example in cancelling appointments with the GP or social worker as he did not see what they would achieve).

5.4.4. DHI have advised that they run a service specifically for families of drug and alcohol users but there is no evidence that information about this service was shared with Martin and his family, or that DHI offered ongoing support to Martin's father.

5.4.5. Virgin Care records did not link Martin with his mother, who was also an adult with care and support needs and known to Virgin Care. This is a further example of a failure to "think family."

5.5. Prescribing practice

5.5.1. Given the coroner's conclusion that Martin "*died as a result of the consumption of a benzodiazepine drug on a background of chronic liver disease due to alcohol*" this review has questioned what attention was paid to cautions relating to the use of benzodiazepines in the context of alcohol dependency

33 Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.
34 Virgin Care submission to the review.

and hepatic impairment[35]. This was a matter of great concern to his parents, who requested any clarification that the review could provide.

5.5.2. Martin's medication was managed by the GP surgery. It was prescribed on a weekly basis and the prescriptions sent to a pharmacy for dispensing. Martin complied with his medication régime, although on occasion there were concerns about over-use. A benzodiazepine was initially prescribed in 2005 on the recommendation of the consultant psychiatrist at that time responsible for his care. The GP practice continued to prescribe the drug and the surgery has given assurance to this review that the cautions would have been noted by the GP within the practice. During the final year of Martin's life (the period under review in this SAR) the GP surgery reviewed medication twice: June and September 2018. In January 2019 the surgery noted that Martin was requesting his prescriptions a day early each week and that he had not attended a GP appointment the previous week. The surgery informed him that he should attend the surgery for review in order for his prescriptions to continue, but he does not appear to have attended a follow-up appointment.

5.5.3. In seeking clarification on the use of a drug about which cautions are in place for patients with alcohol dependency and hepatic impairment, the key question for this review is whether all relevant factors were considered in prescribing it for Martin. It is clear that his liver condition and his alcohol use were known to the GP surgery and his liver condition was monitored. The surgery has provided assurance that both factors were taken into account in their prescribing practice. This provides an important assurance on the question raised by Martin's parents.

5.5.4. However, it does appear that Martin's non-attendance at GP surgery appointments during the final weeks of his life resulted in a medication review not taking place. Despite concerns about his over-use of medication and awareness of his deteriorating health and self-care, his non-attendance was not proactively followed up. This mirrors findings in other SARs [36], where recommendations focus on the importance of assertive follow up of non-attendance at medication reviews, particularly (as here) when prescriptions are long-standing, are addressing multiple needs and the original prescriber is no longer involved.

DOMAIN B: Interagency communication and coordination

5.6. Interagency communication and coordination

5.6.1. The evidence-base for best practice with people who self-neglect recommends inter-agency communication and collaboration, working together [37],

[35] https://bnf.nice.org.uk/drug-class/benzodiazepines.html

[36] The national analysis of SARs highlights concerns about medication management in a number of cases: https://www.local.gov.uk/analysis-safeguarding-adult-reviews-april-2017-march-2019 Other published SAR examples include Mr A and Mrs A (Leeds SAB, 2020) and Kieran (Swindon Safeguarding Partnership, 2021).

[37] Parry, I. (2014) 'Adult serious case reviews: lessons for housing providers.' *Journal of Social Welfare and Family Law*, 36 (2), 168-189. Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

coordinated by a lead agency and key worker in the community[38] to act as the continuity and coordinator of contact, with named people to whom referrals can be made[39]; the emphasis is on integrated, whole system working, linking services to meet people's complex needs.[40]

5.6.2. The evidence-base also indicates the importance of multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequently implement planning and review outcomes.[41]

5.6.3. Virgin Care have observed that a social worker explored what support was available from other agencies, such as, 'deep cleaning', mental health services and specialist supported accommodation. Virgin Health have observed that the community matrons were working collaboratively; however, this may have resulted in a lack of clarity around which one was case managing Martin's case. One liaised with RUH to request that Martin's name be added to hospital tracking for their multi-disciplinary team meeting. Some joint visits were also undertaken.

5.6.4. Agencies contributing to the review have reported some concerns about multi-agency partnership working. Avon and Somerset Constabulary have reported difficulty liaising with Virgin Care. The Constabulary added that, although Martin had an allocated social worker, who was trying to get PCLS to work with him, she left her post in February 2019. The Constabulary did not receive further information about whether a new social worker had been allocated the case and what, if any, handover there had been. AWP have suggested that Virgin Care and RUH misunderstood the role of the MHLT in relation to discharge planning and responsibility for sourcing accommodation. GPs expressed difficulties in liaison with mental health providers when it was felt that Martin had been discharged inappropriately. No feedback appears to have been given to SWASFT regarding their referrals of safeguarding concerns.

5.6.5. After Martin's contacts with acute healthcare, RUH sent discharge summaries to the GP outlining the treatment he had received, and when he had absconded or self-discharged. The summaries usually contained recommendations for follow up in the community where services knew him well. The discharge from the first inpatient admission was robust and Martin was not discharged until the accommodation had been cleaned and community services engaged. The discharge planning was led by DHI. RUH have added, however, that during the hospital discharge process they did not always know which service was

[38] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[39] Parry, I (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[40] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual*. London: Alcohol Concern. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

[41] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual*. London: Alcohol Concern.

leading on coordinating hospital discharge planning or how long it would take for the community services to start to support Martin at home post discharge.

5.6.6. Martin's mother has raised concerns about communications between primary healthcare service and the hospital, believing that the GP's understanding of the seriousness of Martin's physical state, of his risks at home and of the urgency of his need for detox was not taken into account by the hospital A&E department that treated Martin in March 2019.

5.6.7. DHI have reflected that key things that needed to happen (Care Act 2014 assessment, detox assessment, MARMM) seemed to take longer than they should have. Some plans were made but then cancelled either due to Martin being in hospital or the state of his accommodation. However, DHI have suggested that more could have been made of his time in hospital and rather than cancelling meetings they could have taken place on the ward. The first cleaning team sent to Martin's flat was not suitably equipped and a second team had to be arranged. This delay stalled home visits to arrange a detox.

5.6.8. Guinness Partnership as Martin's landlord were not involved in discussions during this period and were not aware of the level of his alcohol consumption or the scale of his self-neglect and neglect of his living environment. The failure of agencies who were aware of his problems to involve the Partnership at this point represents a missed opportunity for them, as his landlord, to contribute to risk-mitigation measures following his hospital discharge. Equally, the Partnership has recognised that, having been informed of the deep-clean, they could have exercised greater professional curiosity and been more proactive in seeking out liaison with other agencies at this point.

5.6.9. DHI have also reflected that there was considerable communication between the various parties involved and a good understanding of the challenges Martin faced. Where the team was less sure was around what support they could actually provide that would make a positive difference. No one practitioner took overall responsibility for the case, including coordination of the MARMM and, without a clear action plan with timescales and accountable individuals, there was a lack of clarity around what was going to happen that would make a real difference in a reasonable time frame for Martin. DHI have concluded that the presence of multiple agencies is actually a risk if there is a lack of coordination as each party feels reassured by the presence of each other but little actually happens. DHI have suggested that the relevant Virgin Care adult social care team should have come forward to lead the multi-agency effort and make sure things were done that needed to be done. In fact a social worker did convene the one MARMM but there is no explicit record of Virgin Care (Adult Social Care) being appointed the lead agency. It may have been assumed that the social worker would be the key worker.

5.6.10. Concerning the MARMM, it has been suggested that any service can convene what is essentially a case conference. However, no explanation has been offered as to why only one MARMM was convened after so many episodes when such a case discussion would potentially have been beneficial in coordinating the multi-agency response. AWP and Virgin Care have suggested that MARMMs are now more commonly held but it appears that no central record exists. Any audit would, therefore, be reliant on services keeping their own register to track MARMM activity.

5.6.11. The community matron did recognise the need for multiagency discussion, and secured Martin's agreement to a MARMM in October 2019, after his discharge from RUH. While not sure who should attend or what it would achieve, given Martin's reluctance to engage with DHI and AWP, she made enquiries with those agencies but received little response. Virgin Care and Virgin Health have both concluded that a MARMM should have been held earlier, when this would have afforded an opportunity to document risks, agree a planned, supportive response, and identify a lead agency. Delay in convening a MARMM represents a missed opportunity.

5.6.12. Agencies have also reflected critically on the MARMM that was held, which was convened by Martin's social worker in February 2019. Not all services that had been involved were invited. It appears the AWP were not notified of the meeting. Considering the number of presentations at ED, it would have been useful for the RUH safeguarding team to be contacted and invited to the meeting or at least to be informed of the outcome. Had the RUH received a copy of the MARMM action plan this could have been added to Martin's records and the team would have been able to place a flag (alert) on his electronic records.

5.6.13. MARMM minutes do not appear to have been shared with all participants. Case notes state that minutes were shared with DHI and Guinness Partnership by post. No minutes were shared with the GP surgery or RUH. At the MARMM, there appears to have been passing mention of Deprivation of Liberty Safeguards (and it is unclear to what this relates) but otherwise no record of discussion of legal options. There is no record of discussion of mental capacity, and no risk analysis or crisis intervention plan evident. It remains unclear why there was only one MARMM and why it was called in February 2019 after a delay of several months. The MARMM is a missed opportunity to pool resources and record agreed actions, with timescales and allocated responsibilities. Indeed, DHI have observed that the MARMM needed to be more effective, noting that some of the right people were there but the wrong questions were asked. The point of leadership was not resolved; a good quality plan was not put in place, with dates for review and nominated agencies accountable for specific actions. The Guinness Partnership have observed that a plan to inspect the property on a joint visit with another agency was frustrated by delays in receiving a response to phone calls, and no inspection visit took place in the weeks that followed prior to Martin's death.

5.6.14. Effective multi-agency working relies on good referral practice and sound, shared recording. Referrals should be detailed where one agency is requesting the assistance of another in order to meet a person's needs, with the "ask" clearly highlighted. Recording should be clear, up-to-date[42] and thorough, of assessments, reviews and decision-making; recording should include details of unmet needs[43]. On referral practice, AWP have observed that agencies need to share enough information at point of referral to enable the service to make appropriate clinical decisions on how to follow up on a case at point of triage. On recording, DHI have observed that the standard of recording around risk

[42] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[43] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

assessment and management could have been higher. Should this case have been subject to a management audit at the time, this would have been picked up. This was one of the first MARMMs that the team had been involved in and therefore there was perhaps a lack of clarity around what best practice looks like. Virgin Care have reflected that recording must illustrate defensible professional decisions and interventions, which are clear and purposeful. For example, distinctions must be made between fact and opinion; decision-making must clearly draw on and test different views, hypotheses and options. The purpose should be clear behind any intervention, such as home visits of telephone calls, including the plan and desired outcome.

5.7. Use of self-neglect, safeguarding and other policies and procedures

5.7.1. The evidence-base on best practice in self-neglect highlights two components here. First, the use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs, with specific pathways for coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital.[44] Second, the use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy.

5.7.2. In summary, there were some missed opportunities to raise safeguarding concerns (when Martin assaulted his mother and some occasions when SWASFT attended him). Guinness Partnership have noted that they missed an opportunity to escalate concern within their own organisation when they became aware in September 2018 that the property had had to be deep-cleaned as a result of Martin's self-neglect. They note that this was in breach of their own safeguarding procedure and indicates a need for improved professional curiosity in pursuing concerns in order to ensure enhanced monitoring and support are put in place where a tenant may be in difficulty. They have provided refresher safeguarding training to their staff since Martin's death.

5.7.3. Not all SWASFT referrals seem to have been recorded as safeguarding concerns, raising questions about how self-neglect is seen and responded to within Virgin Care. No assessment of risk has been recorded, nor the accumulation of concerns noted in January/February 2019. Self-neglect procedures were not enacted until February 2019, and even then the only evident action was the MARMM, which did not result in the required interagency plan and was not followed by other actions set out in the procedures.

5.7.4. On 5th June 2018 the community matron completed a joint visit with Martin's GP, as she was involved with his parents and felt her support would be of benefit. She called the Emergence Duty Team (EDT) to ask for advice regarding safeguarding and was advised that the current situation did not meet the threshold. The Community Matron followed up with ASIST, whilst the GP referred Martin to PCLS. Virgin Care note that the safeguarding referral in June 2018 was closed by ASIST. The contact was originally taken over the phone by

[44] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: PHE.

a care advisor and labelled as a 'Safeguarding Concern'. When the social worker called the community matron, it is recorded that the community matron felt the situation related to 'carer breakdown' and Martin's longstanding issues with mental health. On that basis, it was agreed that the community matron would refer to PCLS and the referral was no longer treated as a safeguarding concern.

5.7.5. Here and elsewhere when reflecting on adult safeguarding referrals, it should be noted that there are only three criteria that should inform decision-making as to whether a safeguarding enquiry[45] should be conducted. These criteria[46] are that the person has care and support needs, is experiencing abuse and/or neglect (including self-neglect) and that, as a result of their care and support needs is unable to protect themselves from that abuse/neglect. The aforementioned statutory guidance adds that, in cases of self-neglect, there should be evidence that the person is unable to control their own behaviour. Arguably, these criteria were fully met in Martin's case.

5.7.6. RUH have reported that on one occasion only did the ED team consider that he was potentially self-neglecting but focused instead on his mental health and alcohol dependency. This led to missed opportunities to make safeguarding referrals. The lessons learnt by RUH include that teams are not recognising self-neglect, particularly in younger people similar to Martin with complex mental health needs and alcohol dependency and so continue to refer to the mental health and alcohol liaison teams. The highest number of referrals received annually by the RUH safeguarding team consistently is for self-neglect and the team have proposed to undertake an audit of 15% of the referrals received in 2019 to establish any themes to include in training for the ED team.

5.7.7. RUH discussed a safeguarding concern with the Virgin Care Hospital Social Work Team in July 2018 in relation to self-neglect. The RUH safeguarding team were informed that a care service coordinator from the adult social care team was involved and a social worker from DHI was liaising with the ward regarding discharge planning. A recent community safeguarding had been closed in June 2018 with a recommendation to refer to PCLS. It was agreed to pursue the concern through care management.

5.7.8. Avon and Somerset Constabulary have reported that safeguarding was considered and put in place for Martin's mother after the alleged assault in December 2018. However, it appears no safeguarding or support was considered or put in place for Martin at this time. Virgin Health did not refer adult safeguarding concern regarding Martin after he had assaulted his mother, perhaps on the assumption that the Constabulary would do so.

5.7.9. SWASFT made 6 safeguarding referrals. There were a further 2 opportunities lost to report the ongoing self-neglect due to staff's incorrect assumption that they did not need to complete a further referral knowing that one had recently been done (this is contrary to SWASFT's safeguarding policy)[47].

[45] Section 42 (2) Care Act 2014.
[46] Section 42 (1) Care Act 2014.
[47] SWAFT has issued a reminder to road staff that as per the SWASFT Safeguarding Policy a safeguarding referral is required at every point of concern, even if one has been completed before.

5.7.10. Virgin Care have accepted that SWASFT reports were not treated as safeguarding referrals and that better documentation was needed in relation to these referrals. There is a record of 3 SWASFT referrals on Liquid Logic, one in January and two in February 2019. There are no explicit records relating to how the SWASFT referrals were taken forward. Virgin Care receive a number of referrals from SWASFT, some of which may not be recorded as a 'safeguarding concern'. Virgin Care have stated that practitioners would usually consider the Self-Neglect Policy in the first instance where appropriate. If the risks relating to a person's self-neglect are low, the usual adult support services may be the most proportionate way of addressing the self-neglect. If not, a MARMM may first be considered to see if the risks relating to self-neglect can be reduced. If the risk relating to self-neglect is high or if previous attempts to work in a multi-agency way had failed to reduce the risk, a safeguarding concern would be usually triggered at that point. Therefore, when a safeguarding referral is received for self-neglect, it may not always be immediately recorded as a safeguarding concern. However, Virgin Care acknowledge that in this case there is no rationale or assessment of risk recorded. There is no evidence that risk was considered or analysed in relation to the accumulation of concerns which could have then triggered a safeguarding concern being raised.

5.7.11. Clarification is required between the two agencies on whether processes for safeguarding referral by SWASFT and for review of such referrals within Virgin Care are robust. Do SWASFT referrals always clearly identify concerns as being raised under safeguarding? What criteria are being used within Virgin Care to ensure SWASFT concerns are placed on an appropriate pathway?

5.7.12. There is evidence too that identifies a more general need to review safeguarding triage within Virgin Care, in particular the interface between Virgin Care and the local authority and the potential for safeguarding decisions not to be appropriately referred to the local authority.

5.7.13. Apart from the MARMM Virgin Care have reported that there is unfortunately little recorded evidence that would indicate that the SAB self-neglect procedures were being appropriately enacted. Virgin Care and Virgin Health have also reported that an action plan is underway to embed self-neglect understanding and that quality improvements with respect to self-neglect practice form part of Virgin Care's priorities for 2020/21, with quarterly progress reporting. The action plan comprises:

- Create an internal Standard Operating Procedure which compliments the LSAB Self-Neglect Policy, incorporating how to work with people who are difficult to engage.
- Self-Neglect Champions roles have been created to promote and support front line practitioners with complex self-neglect cases.
- Revision of Self Neglect Register which will be reviewed regularly.
- Creation of a self-neglect forum- to discuss cases.
- Timescale expectations for colleagues of when to conduct first MARMM and maximum period between reviews.
- Feedback on successes with cases to be regularly shared.

5.7.14. DHI have suggested that more training and regular refreshers are required around the self-neglect procedural framework in B&NES.

5.7.15. Finally, Avon and Somerset Constabulary have provided a detailed analysis of their responses in this case, beginning with their involvement in the incident when Martin assaulted his mother. The initial safeguarding response to this incident was comprehensive, with all appropriate referrals made to partner agencies and risk assessments completed in a timely manner. Their response complied with the Victim Code Of Practice (VCOP) with Martin's mother being spoken to several times and her wishes taken into consideration in the response to the incident. The investigation into the offence was allocated to one of the attending officers on 22nd December 2018 by the supervisor but there was no entry onto the computerised record system until 22nd January 2019. Whilst all initial safeguarding actions had been completed, this delay is not aligned with Avon and Somerset Constabulary's vision of "Outstanding policing for everyone". One month after the incident, the opportunity for effective house to house enquiries, which had been planned, was likely to have passed.

5.7.16. Operational demand is managed using a THRIVE matrix which ensures resource is directed to the highest threat, those at risk of greatest harm and to areas of greatest risk, but also takes into account investigative requirements and vulnerability. Ideally, where an officer is unable to progress an investigation for any reason, a note should be made on the log. The Constabulary has already identified an issue in timeliness of investigative work in recent reviews and this is therefore already under review. In this instance it did not affect the outcome of the investigation, so a separate recommendation is not made. Although there was a delay initiating the investigation, the subsequent investigative approach was thorough and well considered. The Constabulary liaised with the Mental Health Triage team and with Adult Social Care to inform decision-making. It is clear that the officer recognised Martin's vulnerabilities and wanted to understand these more fully by liaising with partner agencies before proceeding with a voluntary interview. There was a good level of supervisory input to the case.

5.7.17. Protocol was followed by the Constabulary for dealing with a sudden death, including liaising with the Coroner and Adult Social Care. Martin's mother's calls were returned and appropriate information provided to signpost her to the Coroner. She was dealt with respectfully and efficiently. The Sudden Death Policy states that officers can leave the scene prior to arrival of the coroner's officer if they have completed their tasks which need to be done at the scene. This decision will be based on professional judgment of a number of factors including operational demand and whether the family is happy for the officer to leave. Whilst it isn't explicit in the policy, good practice would be that the reason for leaving the scene prior to the arrival of the coroner's officer should be recorded and the rationale given. In this circumstance, although the family are visibly upset, they were helpful, co-operative and happy to wait for the coroner's officer to attend. However, due to the squalid conditions in the flat they had to wait in the stairwell for the coroner's officer. The Constabulary has questioned whether, unless there was significant operational demand, it would have been better for the officer to remain on scene until the coroner's officer arrived, allowing the family to go home. This doesn't warrant a

recommendation, and the officer has followed policy, so the Constabulary has raised the point for due consideration.

DOMAIN C: Organisational features of the agencies involved

5.8. Impact of resources and service availability

5.8.1. The evidence-base for best practice highlights the importance of managers attending to the workplace environment to ensure that it facilitates and promotes effective practice. This includes attention to workforce development[48] and workplace issues, such as staffing levels, organisational cultures and thresholds. It includes provision of supervision, support and management oversight that promote reflection and critical analysis of the approach being taken to the case, especially when working with people who are hard to engage, resistant and sometimes hostile.

5.8.2. There were some staff vacancies and use of locum staff in Virgin Social Care. That organisation has also commented previously on the volume of referral demand and the impact this had on the management of referred safeguarding concerns. Other than the one MARMM, Martin was not discussed at any formal meeting, such as the High Impact Meeting, which would have offered the opportunity for support and management oversight.

5.8.3. Commentary above has also referred to a potential commissioning gap, or lack of service availability, with respect to individuals like Martin who experience significant levels of mental ill-health but who are not acutely psychotic and in need of urgent care and treatment. In addition, his mental health needs complicated the response to his alcohol dependence, too complex to be managed in a residential or dry house setting but medical needs making him unsuitable for community detox. His case highlights potential resource/commissioning gaps.

5.8.4. It appears that there are resources available that could be deployed in such cases. These include the Virgin Care Mental Health Community Service, and a mental health reablement service. Other services appear to have been decommissioned, namely floating support and accommodation alongside that support. It would be timely to reconsider whether there are gaps in provision for individuals with a similar constellation of needs to those presented by Martin. AWP have advised that there is mental health support provided through SDAS and DHI for people who have a primary alcohol issue, as often this can be associated mental health concerns. There is also support available through Primary Care Talking Therapies and a number of third sector agencies. The question is whether this is sufficient provision and, furthermore, how to coordinate it in complex and challenging cases.

5.9. Impact of the self-neglect policy and of learning from previous SARs

[48] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

5.9.1. The evidence-base envisages that SABs have a key role in developing policies and procedures, in disseminating learning from SARs, and in seeking assurance that partnership working is effective in preventing and protecting individuals from abuse and neglect. The SAB for Bath and North East Somerset has already completed several SARs, two of which have recently been published[49]. One outcome of that review activity was to revise, launch and disseminate self-neglect procedures.

5.9.2. The services involved with Martin have commented on the steps that have been taken to ensure that lessons are learned from previously completed SARs. Virgin Care have reported that learning opportunities have been provided, with specific attention to mental capacity, executive capacity and reminders to undertake section 9 and section 10 Care Act 2014 assessments, and to be mindful of duties in relation to refusal of assessment (section 11). Virgin Care are familiar with the findings of the previous SARs undertaken by B&NES SAB. The previous PSW is also the author of the SAB self-neglect policy. Knowledge and understanding of self-neglect is embedded within this agency. Virgin Care offer a self-neglect e-learning package for all colleagues. All social workers are expected to undertake the SAB multi-agency level 3 safeguarding adults training. Self-neglect is a standard item on all social care team meeting agendas, supervision and safeguarding governance meetings. Virgin Care has had its own self neglect policy since 2018 and standard operating procedure for 'working with people who are reluctant to engage' since 2019. These were in place after this review period. Overall, Virgin Care's assessment is that knowledge and understanding have improved over the last two years. However, it is recognised that further improvement and embedding of SAR learning is required.

5.9.3. Avon and Somerset Constabulary have offered assurance that safeguarding practices in relation to self-neglect are in place, with referral pathways well established, guidance for staff, and mandatory training.

5.9.4. AWP have advised that learning from SARs is shared through monthly learning from incidents forums. Teams are also very aware of the self-neglect policies and will invoke the MARMM process when identified. DHI have similarly reported that SARs are read and learning extracted by their safeguarding lead. Front line workers and team leaders will not have read the reports. The team in B&NES were up to speed with the Self-Neglect Policy and had attended a training presentation on it after implementation. Self-neglect is something that is encountered fairly frequently, with level of understanding of a good standard.

5.9.5. The RUH safeguarding team have used previous learning from local SARs to inform level 2 adult safeguarding training throughout 2018 and 2019. Staff in the acute environment are continually moving and there is a constant requirement for recruitment of nurses. There are rotational posts for medical staff based in the ED that will be for either 4 or 6 months, so again a frequent change in staffing requiring more senior staff need to be made aware of any learning from SAR's. Bespoke training has been offered and delivered to the ED teams. RUH has a Trust safeguarding policy that cross references to the

[49] Braye, S. and Preston-Shoot, M. (2018) SAR – John; Braye, S. and Preston-Shoot, M. (2019) SAR – Jane.

B&NES policies including self-neglect. The RUH safeguarding team focused on self-neglect, using cases studies, for the level 2 safeguarding face to face training during 2019, with training sessions bi-monthly. There are links on the adult safeguarding intranet page to the B&NES Safeguarding Board/Partnership and policies. The RUH team started publishing quarterly newsletters in 2019; self-neglect was highlighted in one of the editions, which are circulated to senior staff to cascade to their teams and are also available on the intranet.

5.9.6. Virgin Health have observed that learning from previous SARs has been shared widely within the organisation. Application into practice continues to need further work. A joint action plan has been developed to ensure best practice for both health and social care staff. Self-neglect is a quality improvement objective for 2020-2021.

5.9.7. In summary, self-neglect appears to have been embedded in training and SARs discussed in some meetings. Frontline staff should be encouraged to read SAR reports as well as discussing available learning in supervision and team meetings, and acquiring knowledge for practice through briefings. Knowledge of self-neglect across staff groups is reported as good although staff movement and rotation present a challenge in some services. Knowledge of mental capacity is seen as more variable. Application of SAR learning to practice is reported as requiring more work. The SAB should therefore consider seeking further assurance regarding self-neglect practice.

6. CONCLUSIONS

This concluding section summarises the learning that has emerged from the SAR, reflecting the key lines of enquiry set out at the start of the review. It thus provides a context for the recommendations that follow. While some examples of good practice have been found, there is significant learning about some aspects of practice, both within and between agencies, that require improvement. These are set out within the three domains used in the previous section: (i) direct work; (ii) interagency practice; (iii) organisational features. It is important to note that the learning here resonates with familiar systemic issues identified in thematic analyses of SARs regionally and nationally[50], [51] [52], notably:

- Failure to create a secure and robust intervention strategy that meets needs, manages risk and takes full account of mental capacity;
- Failure to coordinate the involvement of all relevant agencies in a shared approach with clear leadership;
- Challenges in the organisational context within which practice takes place.

DOMAIN A: Direct work with Martin and his family

[50] Braye, S. and Preston-Shoot, M. (2017) *Learning from Safeguarding Adult Reviews: A Report for the London Safeguarding Adults Board*. London: London Safeguarding Adults Board.
[51] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.
[52] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for Sector Led Improvement*. London: LGA/ADASS.

6.1. Assessment: Risks were assessed by different services involved as high but there was no completed care and support assessment, no risk management strategy and no crisis intervention plan. Not all agencies had a risk assessment template at the time. The absence of a care and support assessment was a serious omission. His medical conditions were kept under review by his GP surgery and by the RUH during hospital admissions. However, while in the final months of his life his non-attendance at surgery appointments to discuss medication caused concern, repeat prescriptions continued to be issued without review in the context of his deteriorating health and self-care.

6.2. Mental health: Martin's mental health diagnoses differed across the years during which he had contact with mental health services. Little continuity with treatment of his childhood mental ill-health was evident and in consequence it is not clear how, if at all, his adult diagnosis and treatment took account of his earlier experiences. Assessed as not eligible for secondary mental health services, his mental health needs remained un-addressed, raising the question of whether there is a gap in commissioning for services to meet non-acute needs. The current commissioned threshold requires clarification and review in terms of its application. The relationship between Martin's mental health and his drinking posed particular challenges, with different perceptions of which was the primary problem. There was no coordinated plan to address the interaction between them, and neither received effective support. His father has expressed a particular concern about his son's medication in the context of his high alcohol consumption. Martin appears to have fallen into a gap between mental health and alcohol misuse services, again raising a commissioning question about services for people with a dual diagnosis.

6.3. Repeating patterns: Patterns of repeat ambulance calls, hospital attendance and safeguarding referrals were evident, but did not prompt reappraisal of the approach being taken. Until shortly before Martin's death, responses were characterised by 'more of the same' in terms of how Martin's evident distress was addressed. It is possible that the priority given to his drinking, in terms of how his needs were understood, and a consequent absence of professional curiosity masked the potentially more complex picture that lay beneath. The repeating pattern of hospital attendance and self-discharge was one that was of particular concern to Martin's father, who felt that his son lacked effective support following discharge. Martin's mother also shared concerns about post-discharge support.

6.4. Reluctance to engage: While some good practice – for example persistence and flexibility - can be noted, there was a lack of assertive outreach by PCLS, and reliance on standard procedures when greater flexibility was called for. Similarly, greater continuity of care (for example by the GP surgery) may have assisted in building a relationship of trust.

6.5. Mental capacity: Martin's mental capacity did not receive sufficient attention. Other than some assessments by SWASFT and by RUH, capacity was either not considered at all or was inconsistently addressed, with an over-reliance on assumed capacity and an absence of formal assessment, despite the potential impact of his alcohol use. Executive function does not appear to have been considered as a factor in his decision-making on drinking and self-care. RUH noted a need for improved recording of decisions on capacity at points of self-discharge. And although the MARMM discussed a possible need to prevent his self-discharge

when he was next in hospital, with the use of DoLS mentioned, this puzzlingly did not prompt a plan for any capacity assessment while he remained at home. Nor was application to the Court of Protection considered, despite ongoing high levels of concern about risk. It seems there was a degree of paralysis in the interagency system.

6.6. Use of procedures: The actions taken in direct work with Martin do not reflect those that would be indicated in relevant procedures. Recourse to the MARMM was late and even when a MARMM took place it did not produce a viable or coordinated intervention plan. Action under safeguarding procedures was missing, despite a number of safeguarding concerns being raised. This raises questions about safeguarding triage in Virgin Care and whether the local authority can be assured that safeguarding concerns are set on an appropriate pathway.

6.7. Work with Martin's family: Several agencies had frequent contact with Martin's father. He received considerable support from the community matron, who recognised the impact of caring for his son in the context of his own emotional needs, although he declined her suggestion of carer's support. There is, however, no evidence to suggest that Virgin Care, whose responsibility it was to conduct a carer's assessment[53], recognised his needs or offered support, or that DHI's family support services were taken up. It seems that with the exception of the community matron, a 'think family' approach was missing, as was any attention to how family dynamics might be impacting on Martin's behaviour.

DOMAIN B: Interagency communication and coordination

6.8. There were some good communications between some of the agencies involved. Virgin Care attempted to explore sources of support for Martin, and some joint visits involving different agencies took place. One hospital discharge showed particularly robust liaison between hospital and community facilities.

6.9. There were, however, shortcomings in interagency coordination. Some agencies experienced difficulties in communications with other agencies and there was some misunderstanding of agency roles in relation to hospital discharge planning. Referrals between agencies did not always share key information that would enable levels of need and risk to be judged. The community matron experienced great frustration in her attempts to secure responses from other agencies. Guinness Partnership as his landlord were not advised of the scale of Martin's self-neglect early enough in the process for them to play a role in risk mitigation, and their attempts to work jointly following the MARMM were frustrated by a lack of timely response.

6.10. There was considerable delay (four months) between the recognition that a MARMM needed to take place and such a meeting being held, representing a significant missed opportunity. When the MARMM did eventually take place, some key agencies – notably AWP, RUH and the GP – do not appear to have been invited, so informed discussion of all aspects of Martin's situation could not take place. No shared strategy or forward plan emerged, and no lead agency was appointed.

6.11. The Community Safety and Safeguarding Partnership's policies and procedures are intended to support good interagency practice in safeguarding. In

[53] Care Act 2014, section 10

this case, however, there were missed opportunities to raise safeguarding concerns, leading to concerns that self-neglect is not being recognised as a safeguarding issue, particularly in younger people. Safeguarding concerns that were raised were not pursued as safeguarding enquiries. This appears to be in breach of the statutory duty set out in section 42, Care Act 2014, given all the criteria that engage this duty were met. None appear to have been passed to B&NES Council's safeguarding team for decision-making and no account appears to have been taken of the repeating pattern of concerns raised.

6.12. Martin's case was managed under the self-neglect procedure only from February 2019, and apart from the convening of the MARMM no other actions recommended under the procedure took place.

6.13. Other procedures in play in this case relate to the Police response to Martin's assault on his mother in December 2018. Here the Avon & Somerset Constabulary find that appropriate actions were taken at the time, but that there was subsequent delay in entering details into the computerised record system, compromising the potential for timely enquiries to be carried out. Nonetheless the subsequent investigative approach was robust, with appropriate consultation with other agencies to inform decision-making. Police officers were involved also at the time of Martin's death. Here the officer did not remain on the scene once the Coroner's office had been informed and although their actions complied with the Constabulary's Sudden Death Policy it is questionable whether leaving the family alone was entirely appropriate.

DOMAIN C: Organisational features

6.14. Some agencies experienced resource pressures during the period under review, for example staff vacancies and use of locum staff in Virgin Care, which highlights the pressures being faced at the time. As a result, staff turnover there and in other agencies posed challenges of continuity, potentially damaging Martin's trust in his supports, and breaks in communication between agencies. It also compromised staff familiarity with, and understanding of, policies and procedures.

6.15. In addition, there are potential commissioning gaps. First, Martin's mental health made the response to his alcohol dependence more complicated. His needs were too complex to be managed in a residential or dry house setting but his medical needs made him unsuitable for community detox. It is ironic that the Drugs Related Death Group's report to this review observes: *"Given the absence of alcohol in Martin's blood at time of death and the presence of an unknown benzodiazepine type drug it seems possible he was trying to detox himself."* Further exploration is also required of whether there are excessive waits for residential detox within the current pattern of commissioned services.

6.16. Second, there are questions about the availability of services for people with significant levels of mental ill-health but who are not acutely in need of care and treatment from secondary mental health services. This review has found that some services, such as floating support and accommodation alongside that support, have been de-commissioned. Again, the irony here is that Martin himself had told practitioners that he felt he needed such accommodation. Nonetheless this review has learnt that there are community mental health and therapeutic services that were not engaged with Martin, raising a question about the thoroughness with which possible ways of meeting his mental health needs were explored and

whether the provision is sufficient. Coordination of provision in complex and challenging cases clearly remains a challenge and it is possible that the multiple commissioning and funding arrangements result in services that don't quite fit together into a coordinated picture.

6.17. Third, is the question of how local authority duties under the Care Act 2014 are fulfilled in relation to people who do not meet the threshold for secondary mental health services, given the integration of mental health social work within AWP.

6.18. A final question at organisation level is whether agencies have incorporated into their practice the learning from previous self-neglect SARs conducted by the Bath & North East Somerset Safeguarding Adults Board [54] , including implementation of the self-neglect policy, which was revised in the light of the previous SAR findings. It is clear that knowledge and understanding have improved, although the findings from the present review indicate that in the period leading up to Martin's death further improvement and embedding of learning was required. This is perhaps not surprising, given the revised policy was launched only 4/5 months before he died. This does raise the question, however, of whether the Board can be confident that learning and improvement have continued in what is now two years since his death. Agency responses give some reassurance that self-neglect is embedded in training and that learning from SARs is routinely discussed within agencies. Application of SAR learning to practice requires more work, both within agencies and by the Board.

Final reflections from learning event participants

6.19. Participants at the learning event felt that the tragic outcome for Martin could occur again unless significant changes take place. They pointed to organisational fatigue and difficulties finding the capacity to allocate time to people needing regular, intensive support. Without adequate resource and funding, they considered it unavoidable. They advised that cases of serious self-neglect needed to be managed within a stricter framework of shared responsibility, without the pattern of risk being passed back to the agency that has identified it. They pointed also to the professional fatigue that can arise when staff make referrals that do not get accepted; they learn to 'not bother' as it takes energy with no outcome and then end up holding cases with no outcome and feel overwhelmed.

6.20. A more robust use of the MARMM process was considered essential to ensure holistic and shared assessment of all relevant factors within an individual's situation. They also identified a reluctance across the agency network to take on the coordinating role for complex cases. Equally, they raised the question of whether the focus on alcohol dependency, and the frustrations that failure to achieve results can create, combined with assumptions of 'lifestyle choice', militates against the recognition of other needs and achievement of other objectives.

Final reflections from Martin's parents

6.21. Four key issues feature in the concerns expressed by Martin's father and mother. Both consider that their son was not well housed, and that in the context

[54] The Safeguarding Adults Board is now incorporated within the Community Safety and Safeguarding Partnership.

of his mental health needs his accommodation contributed to the decline in his health. While acknowledging that he was reluctant to engage with services, they have commented on the lack of support he received at home, believing that this could have been improved. Martin's mother in particular has expressed concern about information-sharing between agencies, resulting in decisions being made about Martin's treatment without all relevant information being available. Finally, both question the suitability of Martin's medication in the context of his alcohol-related liver disease.

7. RECOMMENDATIONS

The recommendations that follow are intended to contribute to improvements in future interagency safeguarding practice. All are addressed to the Bath & North-East Somerset Community Safety & Safeguarding Partnership to action in collaboration with its relevant member agencies. They are organised by reference to the key domains of safeguarding addressed in this review - direct work with the individual; interagency practice; organisational features – along with a final domain relating to SAB governance.

7.1. DOMAIN A: Direct work

7.1.1. At the learning event the view was expressed that no clear sense was obtained on what Martin saw as the best outcome for himself. It was felt that this complicated the efforts being made to try to engage him. Making Safeguarding Personal is a core principle that underpins adult safeguarding practice and actions undertaken to address self-neglect.

Recommendation One: The Community Safety and Safeguarding Partnership should obtain assurance that an individual's preferred outcomes are obtained and recorded in actions taken under the self-neglect policy and MARMM process.

7.1.2. Carer assessments are also a core component of best practice but although Martin's social worker maintained contact with Martin's father there is no record of a carer's assessment being considered or offered. The community matron did provide considerable support for Martin's parents and offered to refer for further support, which Martin's father declined. DHI also offered support. Even when support is offered, however, carers may not fully appreciate what this might entail and, equally, when in the midst of a situation experienced as a crisis, carers may not prioritise their own needs.

Recommendation Two: (a) The Community Safety and Safeguarding Partnership should consider whether explanatory leaflets should be provided routinely to all agencies to ensure that information on routes to support is available and can be passed to carers who may have support needs; (b) The Community Safety and Safeguarding Partnership should request details of Virgin Care's latest audit of carer assessments to assure itself that the findings of this review are not indicative of a wider systemic issue; (c) the Partnership should request information on the number of carers supported each year by the Carers' Centre and the number who have had a carer's assessment under the Care Act 2014.

7.1.3. At the learning event practitioners expressed the need to improve assessments and provision to those with dual diagnosis and some frustration

that it had proved difficult to secure the right support in response to Martin's mental health needs since his alcohol misuse was a complicating factor. A strong sense was conveyed of individuals being moved around the system. This is addressed alongside other related issues in recommendation thirteen.

7.1.4. Panel members also discussed how diagnoses can evolve over time and the importance of all services being informed of up-to-date diagnoses to inform their own involvement. Martin's latest diagnosis was of alcohol-dependence, schizophrenia and social phobia. This diagnosis would have had significant importance for care and support and for mental capacity assessments. Panel members noted that mental capacity assessment should include a focus on executive functioning, not least because of the possibility of frontal lobe brain damage as a result of prolonged alcohol-dependence.

Recommendation Three: The Community Safety and Safeguarding Partnership should seek assurance on the quality of mental capacity assessments from the task and finish group that is currently reviewing the outcomes of an audit of MCA processes and, in liaison with the task and finish group, consider what action appears indicated with respect to enhancing assessment of executive functioning.

7.1.5. All assessment and intervention should be informed by professional curiosity. Examples of its absence have included participants at the learning event noting the need to seek a deeper understanding of the complex picture that lay below Martin's use of alcohol and of his self-neglectful behaviour rather than make assumptions about "lifestyle choice"; failure to explore why he did not take up offered options for psychological therapies; Guinness Partnership's limited exploration of his support needs as a tenant; absence of reassessment and robust risk mitigation in the light of a repeating pattern of accumulating concerns.

Recommendation Four: The Community Safety and Safeguarding Partnership should include guidance on the value of professional curiosity in its procedural guidance on self-neglect and seek assurance that partners support its use in practice through training and supervision.

7.1.6. Martin had a complex range of physical health needs, presenting alongside his mental health, alcohol use and self-neglect. He received repeat prescriptions for a range of medication, which his GP surgery kept under review. However, in the final two months of his life he did not attend surgery appointments. He was visited at home for blood tests and the GP attempted to refer him to mental health services, but the medication review that the GP had identified as needed did not take place, despite his deteriorating health and concerns about his over-use of medication.

Recommendation Five: The Community Safety and Safeguarding Partnership should request an audit of GP surgeries' compliance with the Clinical Commissioning Group's expectations under its repeat prescribing policy and thereafter a review of guidance to GPs on medication reviews for patients with complex mental health and physical needs. This should include a particular focus on surgeries' systems for alerting clinicians to non-attendance.

7.1.7. Hospital discharge is a key transition point. Contributions at the learning event and discussions with panel members have highlighted some concerns about how discharge, and also Martin's self-discharges, were managed. A particular concern was identified about weekend discharges when mental health and alcohol support services may be less available. When several services are necessarily involved, clarity is required on which agency is leading on and coordinating discharge planning.

Recommendation Six: The Community Safety and Safeguarding Partnership should request that agencies review (through audit or other review mechanism) whether hospital discharge processes in cases of self-neglect involving mental ill-health and alcohol-dependence (including both planned discharge and self-discharge) result in robust follow-up and coordination of post-discharge provision.

7.2. DOMAIN B: Interagency communication and coordination

7.2.1. Agencies working together is a core component of best practice with people who self-neglect. At the learning event there were observations that joint working needed to improve, for example between mental health and substance misuse services, and community and acute health care services. Service provision was not always experienced as seamless. Practitioners expressed some uncertainty about the process to follow for the appointment of a lead agency when there are several services involved.

Recommendation Seven: Based on the findings of its audit of MARMM processes, the Community Safety and Safeguarding Partnership should identify priorities for enhancement of multiagency collaboration in self-neglect work.

7.2.2. One mechanism for strengthening how services work together is the use of multi-agency risk management meetings. At the learning event it became clear that a community matron had identified a need for a MARMM in October 2018 but was unsure to whom to direct a request that one be convened. Criticisms were also expressed of the one MARMM that was held, especially its apparent failure to appoint a lead agency and key worker, and to progress thorough mental capacity assessment. Panel members have expressed the view that practice regarding MARMMs has improved, with a greater number of meetings being held. Nonetheless, there does appear to be some uncertainty surrounding MARMMs: for example whether any agency can convene and lead a meeting or whether the responsibility should reside in adult safeguarding, who should take responsibility for the production of minutes, and where overall responsibility for the MARMM approach sits.

Recommendation Eight: The Community Safety and Safeguarding Partnership should ensure that its current audit of the MARMM process leads to actions that clarify and strengthen how the process is used.

7.2.3. Another key component of best self-neglect practice, and management of practice, is recording. At the learning event it was observed that mental health and substance misuse providers use different IT systems, and that the recording of mental capacity assessments required improvement.

Recommendation Nine: The Community Safety and Safeguarding Partnership should request the task and finish group that is currently reviewing the outcomes of the audit of MCA processes to ensure that the quality of recording of mental capacity assessments has been reviewed and that action is taken to seek any necessary improvements.

Recommendation Ten: The Community Safety and Safeguarding Partnership should seek assurance on how the Integrated Care Record captures (i) actions taken to address self-neglect and (ii) attention given to mental capacity.

7.2.4. Discussions at the learning event and in the SAR panel highlighted that practitioners felt unclear about the pathway to follow to escalate concerns about wellbeing, and that sometimes concerns were labelled as safeguarding in order to elicit a response. It further emerged that some safeguarding concerns reported by agencies (in this case SWASFT) are not recorded as safeguarding concerns by Virgin Care, leading the review to question whether the local authority could be assured that triage of referred adult safeguarding concerns was robust, and that it is appropriately consulted and involved in decision-making.

Recommendation Eleven: The Community Safety and Safeguarding Partnership should conduct an audit of decision-making regarding adult safeguarding concerns that do not progress into any safeguarding decision-making or MASH discussion.

Recommendation Twelve: The Community Safety and Safeguarding Partnership should seek assurance that processes for safeguarding referral by SWASFT and for review of such referrals by Virgin Care are robust. Do SWASFT safeguarding concerns always clearly identify that they are being raised under safeguarding? What criteria are used within social care to ensure that concerns raised by SWASFT are placed on an appropriate pathway?

Recommendation Thirteen: In the light of outcomes arising from its escalation policy review and adult safeguarding audit, the Community Safety and Safeguarding Partnership should consider whether further guidance and/or training is required on how to escalate adult safeguarding concerns.

7.3. DOMAIN C: Organisational features

7.3.1. Various "gaps in the system" were highlighted during the learning event and panel discussions. For example, AWP highlighted that it is not currently commissioned to provide a mental health assertive outreach service. Whilst individuals whose mental health needs do not reach the threshold for crisis intervention would be signposted to other mental health provision by AWP, questions were asked about the adequacy of provision that might be available and whether signposting alone was sufficient response, especially for people whose lives involved chaos and complexity, shame and isolation. Concerns were expressed about the long waiting time for residential detox, the limited resource within RUH on alcohol nursing support, and about perceived gaps in services for individuals with dual diagnosis. Indeed, Martin's case is illustrative that some individuals need wrap-around support not just in times of immediate crisis.

Recommendation Fourteen: The Community Safety and Safeguarding Partnership should convene a summit of commissioners and providers to use this SAR as a case study to explore gaps in provision and to identify priorities for service development. As part of this process, the Community Safety and Safeguarding Partnership should in particular seek assurance from alcohol and mental health commissioners that dual diagnosis pathways are reliable and effective.

7.3.2. Practitioners attending the learning event felt that the self-neglect policy, which had been launched during the timeframe of this case, had yet to become fully embedded in practice and that not all practitioners may have been aware of it or had a full understanding of what was expected.

Recommendation Fifteen: The Community Safety and Safeguarding Partnership should ensure that the learning from this SAR informs their ongoing work to promote the self-neglect policy and to communicate policy expectations concerning practice and the management of practice in self-neglect cases.

7.3.3. Those attending the learning event spoke of quite severe system pressures within their agencies, observing the huge increase in referrals as an example. As panel members observed, this can result in resource protectionism. One manifestation of this challenge was felt to arise in cases of individuals where neither MARMMs nor adult safeguarding enquiries had been able to mitigate significant risks.

Recommendation Sixteen: The Community Safety and Safeguarding Partnership should, going forward, monitor the effectiveness of MARMM and adult safeguarding processes in high-risk complex cases where multi-agency work has been unable to mitigate risk and consider, in the light of emerging evidence, how interagency risk management processes can be strengthened.

7.4. DOMAIN D: SAB Governance

7.4.1. This is not the first SAR involving self-neglect that has been completed in Bath & North East Somerset since the implementation of the Care Act 2014. Briefings highlighting learning from earlier SARs have been produced but no mechanism has apparently been used to receive feedback on how the briefings have been used to shape practice and enhance management of practice.

Recommendation Seventeen: The Community Safety and Safeguarding Partnership should continue its practice of reviewing the outcomes of actions taken in response to previous SAR recommendations and determine what follow-on action is required to embed service improvement and enhancement.

Recommendation Eighteen: When SAR briefings are disseminated to services and teams, a feedback sheet should be attached with a requirement that feedback is given to the Community Safety and Safeguarding Partnership on when and how the briefing was used and how practice is being overseen, in order to strengthen agencies' accountability for their learning.

7.4.2. There were requests for training on working with individuals whose circumstances reflect the challenges experienced in this case.

Recommendation Nineteen: The Community Safety and Safeguarding Partnership should review current training to ensure that it captures learning from this SAR. In addition, it should commission multi-agency training to promote learning on self-neglect and mental capacity when alcohol-dependence, repetitive patterns and concerns about executive functioning feature. All training should emphasise the importance of accessing legal advice, a component of best practice that has been highlighted by other SARs completed by the Safeguarding Partnership in Bath and North East Somerset.