Safeguarding Adult Review

‘John’

OVERVIEW REPORT

September 2023

Jon Chapman

Acknowledgements

Governance

The author can declare that he has no conflict of interest in completing this review, and that he is independent to Worcestershire Safeguarding Adults and Children Partnership Board and partner agencies. The report has been commissioned by, and written for, the Partnership and overseen by a multi-agency panel of local senior managers and practitioners from the following agencies:

- Worcester County Council Adult Social Care (WCC ASC)
- Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT)
- Herefordshire and Worcestershire ICB on behalf of Primary Care
- National Probation Service (NPS)
- Worcestershire Acute Hospital NHS Trust (WAHT)
- West Mercia Police (WMP)
- West Midlands Ambulance Service (WMAS)
- Hereford and Worcester Fire and Rescue Service (HWFRS)
- Advance Housing and Support
- Maggs Day Centre
- Cranstoun
- Worcester City Council Housing

The details of the adult and their family, as well as the individuals providing care to them, have been anonymised in accordance with statutory guidance and best practice.

Contents

1.0 Introduction

1.1 John died in March 2022; at the time of his death, he was 54 years of age. Over a period of years John had become very well known to agencies. He misused substances, namely alcohol and street purchased Oramorph. He suffered the loss of his mother in 2015 and his father in 2022. This loss of his family network had a significant impact on him.

1.2 There had been a history of concerns over John neglecting his own care and there were repeated occasions where he attended hospital following self-inflicted medication overdoses some of which we believed was intentional. In March 2022, John was found deceased at his home address.

2.0 Why a review

2.1 The purposes of a SAR are: -

- Learn from cases where there are clear concerns that agencies have not worked as well together as they might; and which demonstrate areas of practice that could have been delivered more effectively, and additionally: -

- Consider whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented, and use that consideration to develop learning that enables the safeguarding adults partnership in Worcestershire to improve its services and prevent abuse and neglect in the future.

- Agree how this learning will be acted on, and what is expected to change as a result.

- Identify any issues for multi or single agency policies and procedures.

- Publish a summary report, which is available to the public.

2.2 The Worcestershire Case Review sub-group considered this case from the referral for a SAR by undertaking a rapid review of the case. The sub-group was presented with information from all the agencies involved. The sub-group determined that the case did meet the criteria for a Safeguarding Adult Review. The sub-group also noted that the case repeated themes that had been evident in previous local and national Safeguarding Adult Reviews.

2.4 Recognising the repeating themes it was agreed that this review would be conducted on a more strategic basis than is usually the case. Terms of reference were developed (appendix A) which determined that the methodology: -

'*This review will build on the scoping from the rapid review process and use the basis of this case to better understand what are seen as repeating themes within the partnership. This will be conducted by using this case for a strategic workshop'*

2.5 The terms of reference also identified several key lines of enquiry.

- Was self-neglect and hoarding identified and what action was taken to address these issues?

- What policies and procedures were in place at the time, were they effectively used and if not, what were the barriers to this?
- What services were involved with John and was the action taken by them coordinated and complimentary?
- What services were available to support John with substance misuse/mental health/physical health? How did they manage any disengagement?
- Were there safeguarding concerns / fluctuating capacity issues, if so, were they appropriately identified and addressed?
- How was the risk of firearms and offensive weapon possession managed and was information shared effectively to facilitate risk assessment?
- What was the impact of Covid on John and services he received? What was the impact on those services delivering them?

Partnership specific

- What was the impact of the reduction of the Blue Light Project?
- How would the revised self-neglect policy and CARM process have impacted on this case? How well understood are the processes?

The review will focus on the period 1st May 2018 to the date of John's death 18th March 2022.

3.0 Why a strategic review

3.1 There have been a number of Safeguarding Adult Reviews in Worcestershire that have featured self-neglect and the issues associated with this behaviour.

3.1.1 Case of RN (published 2017)[1]

This case in 2015 related to a man in similar circumstances as John, he was dependent on alcohol, with mobility issues and serious ill health, who lived alone. There were concerns around self-neglect. This case which is now over seven years old recognised that at the time of the review identification of self-neglect was more limited. This case made recommendation that the then self-neglect policy was reviewed, and the role of lead professional should be introduced.

3.1.2 Case of BS (published 2021)[2]

This was a case of an isolated lady who died in 2019, in which self-neglect was a feature and in which recommendation was made that the Worcestershire Safeguarding Adult Board should re-launch the self-neglect policy with a focus on readability for practitioners, highlight hoarding in a separate section and include sections of professional curiosity and how to work with people who are difficult to engage.

3.1.3 Case of Mr and Mrs Jones (published in 2020)[3]

This case involved an elderly couple who, in 2019, wished to be self-sufficient and were resistant to support but featured self-neglect. The review recommended a review of the self-neglect procedure and advice on convening multi agency meetings.

[1] RN SAR - https://www.safeguardingworcestershire.org.uk/documents/sar-rn/
[2] BS SAR - https://www.safeguardingworcestershire.org.uk/documents/learning-brief-for-professionals-bs/
[3] SAR Mrs and Mrs Jones - https://www.safeguardingworcestershire.org.uk/wsab/sars/

3.1.4 Case of Joan, Kate and Laura (published 2021)[4]
This case involved a mother and her two daughters who had learning difficulties. As the daughters transitioned from childhood to adulthood there was evidence of self-neglect. The case spanned a significant time period but came to the attention of the Safeguarding Adult Board in 2018. The recommendations of the review included seeking better identification of self-neglect and the relationship with mental capacity.

3.1.5 Thematic Safeguarding Adult Review on those persons who sleep rough (published September 2020)[5] This was a significant review which looked at themes emanating from four cases involving persons, who were homeless and died. One of the specific terms of reference was to examine the issues of self-neglect as a Care Act 2014 category of safeguarding as it links to issues for rough sleepers. The review also considered a case of another person who did not die.

3.2 These reviews indicate the prevalence of cases involving self-neglect that have reached a critical stage. As a result, the self-neglect guidance was rewritten and launched in July 2022.[6] This policy recognises that self-neglect was a feature in 78% of SARs in Worcestershire between 2017 and 2019. This picture is echoed nationally with 45% of SARS nationally featuring self-neglect.[7] The timing of this review allowed for the consideration of the implementation of the new policy and the related Complex Adult Risk Management (CARM) framework.[8]

3.3 These repeat factors taken with two new cases which have been recently referred as Safeguarding Adult Reviews indicated that there was the need for the Safeguarding Adults Board try to understand what action could be undertaken at a strategic level to reduce the number of cases involving self-neglect reaching a critical stage.

4.0 Strategic workshop

4.1 Safeguarding Board Priorities

4.1.1 The strategic workshop discussed the current Worcestershire Safeguarding Adults Board priorities [9], which at the time of the discussion were: -

- Making the system work
- Joint working
- Wicked issues (e.g., Complex Multi-Agency issues.)

These priorities have remained the same over the past two years, due to the covid pandemic. It is recognised that these priorities are very broad, and the Board will be seeking to develop more specific priorities for the year 2023/2024.
However, the issue of self- neglect does fit well into all of the current priorities.

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[4] SAR Joan, Kate and Laura - https://www.safeguardingworcestershire.org.uk/wsab/sars/
[5] Thematic Safeguarding Adult Review on those persons who sleep rough - https://www.safeguardingworcestershire.org.uk/wsab/sars/

[6] Worcester shire self-neglect policy - https://www.safeguardingworcestershire.org.uk/about-us/what-is-safegaurding/who-needs-safeguarding/self-neglect/
[7] Analysis of Safeguarding Adult Reviews: April 2017 - March 2019
[8] https://www.safeguardingworcestershire.org.uk/about-us/what-is-safegaurding/who-needs-safeguarding/

[9]

It is suggested that when developing the Board priorities based on the evidence of from reviews dating back to 2017 that consideration is given to promoting the new self-neglect policy.
Consideration should be given to innovative ways to deliver the learning from the reviews and the new policy to professionals. Evidence has shown that the previous policy was not used effectively. This is the case as recently as early 2022, which is the time that this review John was effective.

Recommendation 1
The Worcestershire Safeguarding Adults Board should when developing Board priorities consider the promotion of understanding and dealing self-neglect and the refreshed policy.

4.2 Self-neglect and CARM policies

4.2.1 The Worcestershire Safeguarding Adults Board has reviewed the self-neglect policy and developed a Complex Adult Risk Management (CARM) framework. The CARM policy seeks to provide front line practitioners with a framework to facilitate effective working with adults who are at risk of harm due to their complex needs, and where the risks cannot effectively be managed via other processes or interventions, such as section 9 care and support assessment or section 42, safeguarding enquiry under the Care Act 2014. The CARM guidance is used when the adult's engagement with support is intermittent or where it has proved difficult to engage with the adult, and they continue to be at risk, and individual agency procedures have not been able to resolve the problem(s)[10]. The guidance is only used where there has been a mental capacity assessment and the person is deemed to have capacity around the decision putting them at risk, and they continue to put themselves at risk of serious harm.

4.2.2 The CARM policy sits alongside the self-neglect policy and refers practitioners to this policy where appropriate. Both policies were well launched in May 2022 and have an associated suite of documents to assist practitioners. The discussion for this review considered why professionals had been reticent to use the previous self-neglect policy and considered a concern that the newly launched CARM and self-neglect policy would be similarly utilised.

4.2.3 It was believed that one of the reasons that the previous policy was not used was a lack of confidence that agencies had to initiate and convene a multi-agency meetings. There was also a concern that agencies felt that having initiated the process they would then bear the responsibility for the process. The new processes have been designed to offer support and there are plans for a CARM coordinator to be established.

4.2.4 The discussion also focused on the possibility of there being some confusion from practitioners on which policy to use in certain circumstances. Early indications had been that practitioners tended to use the CARM policy. It was clear that there would need to be early support and guidance. It was acknowledged that ad hoc multi-agency meetings may be difficult to achieve, and it would be worthwhile considering how a regular structured meeting could be achieved to manage cases in a similar fashion to that achieved in other multi-agency arenas (e.g., MARAC and MAPPA) and how this would fit with other meeting structures.

[10] CARM Guidance - https://www.safeguardingworcestershire.org.uk/documents/complex-adult-risk-management-carm-final-v2-august-2022/

Recommendation 2
The Worcestershire Safeguarding Adults Board should monitor the progress of the use of the self-neglect and Complex Adults Risk Management framework. This should include the introducing the role of CARM coordinator and consideration of piloting regular CARM/self-neglect management meetings.

4.3 Dual Diagnosis (Co-occurring conditions)

4.3.1 Worcestershire Safeguarding Adults Board commissioned The Thematic Safeguarding Adult Review on Those Persons Who Experience Homelessness. In the terms of reference there was focus on those persons who may experience the reality of one or more physical health needs, a mental health need and where relevant, dependency on one or more substances, all at the same time. The recommendations that the report made regarding this particular issue naturally focused on those who experienced homelessness.

4.3.2 Research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in community substance misuse treatment.[11] It is also known that persons with co-occurring conditions are sometimes excluded from services.
The Public Health England (PHE) guide for commissioners developed with the support of NHS England sought to support local areas to commission timely and effective responses for people with co-occurring conditions. It encourages commissioners and service providers to work together to improve access to services which can reduce harm, improve health and enhance recovery, enabling services to respond effectively and flexibly to presenting needs and prevent exclusion.[12]

4.3.2 NICE guidance of 2016[13] (updated January 2022) recommended that commissioners of mental health, substance misuse, primary care and local authorities when commissioning support services, including housing and other services provided by the public, community and voluntary sectors should ensure that secondary mental health services do not exclude people with severe mental illness because of their substance misuse.

4.3.2 There needs to be a discussion in Worcestershire as to how persons with co-occurring conditions (dual diagnosis) are able to access assessment for secondary mental health services. At the strategic discussion it was believed that the reason that John could not access secondary mental health services was that there was no commissioned service.

Recommendation 3
Commissioners of mental health and substance misuse services in Worcestershire should consider how secondary mental health services and substance misuse services can work together to provide a service to those persons with co -occurring conditions.

4.4 Treatment Resistant Drinkers

4.4.1 John was alcohol dependent and had been since 2006. His GP noted that he had fluctuating engagement with alcohol services. For a period of time John engaged with the Blue

[11] Weaver et al (2003) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. The British Journal of Psychiatry Sep 2003, 183 (4) 304-313
[12] Public Health England (2017) Better care for people with co-occurring mental health and alcohol/drug use conditions A guide for commissioners and service providers
[13] NICE, Coexisting severe mental illness and substance misuse: community health and social care services (NG58), 2016

Light Project.[14] Professionals who worked with John at the time and his family would say that during the period of the support from the project he was at his most stable. The records at the time would support this indicating that there was a reduction in call to emergency services from John.

4.4.2 Discussion at the strategic event suggested that the Blue Light project ceased to exist at around the time of the first national pandemic lockdown (March 2020) although this may not have been the reason. The Blue Light Project was being trialled in two areas of Worcestershire and formed part of the Reducing Harm from Alcohol Plan 2016-2021.[15] The Worcestershire Drug and Alcohol Joint Needs Assessment (JSNA)[16], 2020 identified that the Blue Light Project had been endorsed by stakeholders as an example of partnership working that was effective. The Blue Light Project was also cited as good practice in the previously mentioned thematic review into safeguarding those persons who sleep rough.

4.4.3 There is sufficient evidence from this review and from other sources to initiate a discussion on the future of the Blue Light Project in Worcestershire.

Recommendation 4
The Worcestershire Safeguarding Adults Board should initiate discussions to establish what the future of the Blue Light Project is in Worcestershire.

5.0 Background to the John's case and family views

5.1 John had been alcohol dependent for a number of years and received counselling for this dating back to before 2015. In 2015, John's mother passed away. This impacted significantly on him, and he received grief counselling to help support him. John lived alone in a flat but remained in contact with his father, who died in 2022. It is of note that on more than one occasion John stated that when his father died, he would seek to take his own life.

5.2 John's family describe him as a loving, funny and caring father, son and husband when he was sober, which hadn't been the case for a number of years. When in drink John had a propensity to be aggressive and could be violent. He separated from his wife and children in 2009, but maintained limited contact with the children through his mother and father. The level of contact very much depended on the extent of John's alcohol use.

5.3 Although the family worked hard to support John, his addiction to alcohol and more latterly to painkillers or prescribed medication made relationships difficult to sustain. He was very close to his parents and the family confirm that he found their deaths difficult to manage. His family state that going back to his early life John had most tasks done for him. Initially by his parents and then his wife. Due to this he did not cope well with simple tasks such as keeping appointments. His substance use added to this inability to complete the simplest of daily life tasks. His family also state that John had very poor reading and writing skills and was almost illiterate. These factors taken together offer some understanding on levels of engagement by John with some agencies.

5.4 Both of John's children, who are now adults have been diagnosed with forms of neurodiversity and the family would, on reflection question whether this could have been an

[14] The Blue Light project – a project which includes evidence-based interventions and training for professionals, aims to provide support to people who have entrenched problems with alcohol.
[15] Reducing Harm from Alcohol Plan, 2016-21, Worcestershire Health and Wellbeing Board
[16] Drug and Alcohol Joint Strategic Needs Assessment, 2020, Worcestershire Health and Wellbeing Board

unrecognised condition for John. More latterly John disclosed trauma in his life in the form of sexual abuse, when he was a child. The family had no indication that this had occurred and to their knowledge it is not something that John had disclosed with anyone else. The family, again on reflection believe that this trauma, which they only became aware of post his death may have accounted, in part, for his substance misuse.

5.5 More latterly John was supported extensively by Maggs Day Centre and by his GP who often saw him in the Day Centre clinic. There were historical reports of concerns over John suffering self-neglect, that he was depressed and having suicidal thoughts. This resulted in regular hospital presentations. Between April 2017 and March 2022 John attended the hospital emergency department on 167 occasions. Many of these presentations were for a similar theme, for overdose on medication for chronic back pain, either accidental or with suicidal intent. On many occasions the police were also in attendance due to John's demeanour. John often left the hospital prior to assessment or treatment by either absconding or self-discharging himself.

5.6 There were a number of mental health assessments following attendances at hospital for depression and overdoses. Secondary mental health services were not able to accept John due to his high and unstable use of alcohol. There was no apparent access to services in Worcestershire for persons with a dual diagnosis of alcohol or drug dependency and mental health issues.

5.7 Much of the support provided in 2016 and 2018 was focused on encouraging John to clear his flat, there were references to the living conditions and that John was hoarding. Whilst there was significant support there is no reference to any policies to assist in manage this. John received support to ensure that he was able to maintain his tenancy and was not made homeless but there was a continued trend for John to self-neglect, which was linked to his lifestyle and substance dependency. On occasions agencies found it difficult to contact John, but it was not clear from records how this contact should be made.

Recommendation 5
Agencies should explore and record with a person at the time of initial contact what their preference on methods of future contact are.

6.0 Narrative Chronology

6.1 At the beginning of 2018, John was being supported by Blue Light Project[17]. This project was initiated in some areas of Worcestershire. Notes from a Blue Light meeting of April 2018 indicate that there were attempts to support John to clear his flat. The records show that at this time there was rubbish '3 feet deep' across the flat.

6.2 In June 2018, Adult Care Services commissioned a care provider to deliver 4 hours support to John each week. This support included support with correspondence and benefits. There was support with healthy eating and shopping and maintaining his home environment and emotional support. Overall John's engagement with the provider was said to be poor and this was reported to Adult Social Care.

[17] The Blue Light project is an initiative to develop alternative approaches and care pathways for drinkers who are not in contact with treatment services, but who have complex needs.

6.3 During 2018, John presented at hospital on 12 occasions, 7 of these concerned overdoses of medication. The management through Blue Light sought to reduce the calls made to the 111 services by John. On two of the hospital attendances John sought to discharge himself. His mental capacity to make this decision was assessed and, on both occasions, he was deemed to have capacity to make this decision and understand the potential risks and consequences that this action entailed.

6.4 At the beginning of 2019, the was a multi- agency meeting that was chaired by the substance misuse support agency and was well attended by agencies. John also attended this meeting. The notes of this meeting show that the state of the flat was again considered and the housing provider was to instigate the Hoarding Procedure. John‘s flat was also visited by the Fire Service and smoke alarms were fitted.

6.5 During 2019, John was still being supported by the Blue Light Project and subject to regular multi agency meetings. There was a noticeable reduction in the attendances at hospital with only 5 in a year period. Only two of these related to overdoses. There was also a reduction in the number of calls made to the 111 service (6 calls in the month of February). There was also evidence in February 2019, of the hoarding action plan having a positive effect. This was believed to be as a result of the multi-agency support being provided.

6.6 In April 2019, John was at risk of losing his tenancy due to large rent arrears. He was supported by Maggs and Worcester City Council Housing Solutions to appeal the eviction, which was successful. There was evidence that John continued to progress well with the hoarding plan, although there was still a lot of work to be undertaken to clear the property.

6.7 The Fire and Rescue Service raised a safeguarding concern regarding significant hoarding in September 2019, due to the conditions of the property but this was closed as information was passed to the allocated social worker, in accordance with the self-neglect policy at the time.

6.8 In September 2019, John disclosed historic sexual abuse to a Maggs support worker. He did not wish to discuss the matter further or to accept counselling at this time. There was evidence of continued improvement and good inter agency working, with a skip being delivered in November 2019 and further clearance of the address.

6.9 John’s progress continued into 2020 but there was a noticeable decline around the time of the Covid pandemic and associated lockdown in March 2020. This decline coincided with the withdrawal of the Blue Light Project. By April 2020, the GP documented that John was feeling very low and lonely and that he reported that his flat was a mess again. The GP and Maggs continued to support John but contact was sometimes difficult, with John not answering calls.

6.10 In March and May 2020, John was admitted to hospital having suffered seizures. On both occasions, following assessment, he was discharged home.

6.11 In October 2020, John disclosed to the Maggs support worker that he was very low and planned to take his life at some stage. He stated that he had no immediate plans but would do this when his father died. Three days later, John referred himself to the mental health service. He again stated that his father was unwell and when he passed away, he would take his life and had started to plan his life around this course of action. There were

two attempts to follow this up but after failing to make contact John was discharged from the service. It is not clear how this contact was attempted.

6.12 Within a week of this contact and discharge from service John made multiple calls to the mental health crisis team. He was believed to be intoxicated and stated an intention to take his life. John was taken to hospital and his mental health was assessed. At an appropriate stage his mental capacity was assessed, and he was deemed to have capacity to make decisions regarding his health. His issues were considered social issues. These feelings of suicide linked to his father being unwell continued to be disclosed to agencies as they dealt with him. This included the hospital which he attended at the end of October when he mentioned going to the train station to kill himself.

6.13 In February 2021, there were concerns for John's welfare as contact had been limited over the preceding months and he could not be contacted. He was reported as a missing person and due to his vulnerability was deemed to be of high risk. He contacted various agencies and stated an intention to take his life. He was located having jumped into the canal and arrested for being drunk and disorderly. After an assessment in custody, John was charged with an offence and released.

6.14 At the end of February 2021, John was again admitted to hospital presenting with alcohol intoxication and an overdose of medication. John was assessed over the phone by the mental health crisis team but refused to engage. John was considered to have mental capacity to make decisions regarding his treatment, which he refused and he discharged himself form the hospital.

6.15 John continued to be supported by Maggs and his GP, in April 2021 he again discussed being sexually assaulted by two adults when he was aged 9. He said that he had sought support for this, but mental health services could not help him.

6.16 In May 2021, the police had two contacts from John. The first was well dealt with by a call taker and was deferred to the ambulance service. The second police attended and submitted a detailed report to the housing provider describing unsanitary and dangerous living conditions. A referral was also made by the attending officer to the police Harm Assessment Unit (HAU) but no onwards referral was made to Adult Social Care. The police also seized a firearm (air weapon) and a knife from the address. There was no marker placed on the address for firearms and this point went on to cause considerable confusion and concerns when other agencies were later attending the address. The firearm and knife were returned to John by police at the beginning of June 2021.

6.17 At the end of June 2021, there was a joint visit by police and the housing provider, they noted that the condition of the flat was poor and that John was not washing or caring for himself. The housing provider liaised with the Maggs support worker and considered moving John to a more suitable and accessible address. It was deemed that enforcement action was not appropriate due to John's vulnerability. The allocation of a new address was progressed with a multi-agency meeting with John in August 2021 and the allocation of a new tenancy in September 2021.

6.19 At the end of August 2021, John called police regarding his mental health. Police requested that an ambulance attended which was declined without police presence as there

had been a previous firearms incident. Ultimately the ambulance, after further discussion did attend the address.

6.20 At the beginning of September 2021, police were involved with John on a number of occasions. He was ejected from a public house and found to have removed a steak knife from the premises. On two occasions the attending police submitted a referral to the HAU but on both occasions no further referral was made to other agencies on the rationale that John was not in need of any further community care services.

6.21 There were a number of calls to police where John stated suicidal intent, the calls were appropriately dealt with but the confusion over the possession of firearms remained. The ambulance service asked for police support in September, on one attendance but were told that there was no record of John possessing firearms. The police control room seemed unaware that the firearm had in fact been returned to John.

6.22 At the beginning of October 2021, John reported the theft of his wallet from his home via a support worker. This investigation was closed on the basis that the crime desk could not make contact with John. The police submission for this review indicated that this matter should have been referred to the HAU for consideration.

6.23 In mid-October 2021, John was admitted to hospital following an overdose of medication and Oramorph. On discharge he threatened suicide to the Maggs support worker. Police were informed who signposted the enquiry to the ambulance service.

6.24 At the beginning of November 2021, various services received calls from John that he intended suicide. John was located and voluntarily attended hospital where he disclosed alcohol abuse and an overdose of medication.

6.25 At the beginning of November 2021, ambulance again requested police assistance with attendance at John's address on the basis of there being firearms seen previously, it was again not apparent that the firearm had been returned. There were numerous calls to both police and ambulance service during November and early December. At the end of November 2021, John was again conveyed to hospital following a medication overdose with an intent to end his life. John declined to engage with the crisis team.

6.26 At the beginning of 2022, John continued to contact agencies and state that he was suicidal. At the beginning of February 2022, John's father passed away. John discussed this with both the Maggs support worker and the GP. He also again mentioned the previous sexual abuse. Support for bereavement and sexual abuse counselling was discussed with John but not accepted by him at this time.

6.27 At the end of February 2022, police received third party information that a firearm had been witnessed at John's address. This was assessed and deemed that as it was non corroborated information it would be made subject of an intelligence report. This information was not shared with other agencies. During January and February 2022, the care provider received no response when calling at John's address on a regular basis and reported this to Adult Social Care.

6.28 At the beginning of March 2022, ambulance received a call from John with a report of what appeared to be a heart attack during this call John disclosed that he had a gun and

police attendance was requested. On attendance a BB (ball bearing) gun was recovered. John declined hospital treatment, but it was noted that his living conditions were poor and he had no heating due to lack of funds. The call was reviewed by HAU but no referral was made to other agencies on the basis that health (ambulance) were involved and any safeguarding concern should be reported by them.

6.29 In mid-March 2022, there was an escalation of concerns, John was seen by the Maggs support worker in a very unclean state, but he refused assistance. Four days later the support worker called an ambulance as John was feeling suicidal. On this occasion the ambulance service felt that John did not have capacity and sought to use section 5 Mental Capacity Act[18] to take John to hospital. The ambulance service recorded that John had previously produced a handgun and as a result a firearms incident was declared and John was detained while the flat was searched, no weapon was found. John was left in the care of a friend.

6.30 Four days after the police and ambulance attendance a friend found John deceased at his address. Close to where he was laying were a number of vodka bottles, 2 empty Oramorph bottles and a packet of painkillers

7.0 Discussion

7.1 Most of the key lines of enquiry have been addressed within the discussion on the strategic issues. This section will focus on those areas which are more specific to this review.

7.2 More latterly John made disclosures of sexual abuse dating back to his childhood. He spoke about this to the Maggs support worker, mental Health Crisis team and his GP. These were matters that he had not previously disclosed as far as it can be ascertained. They were issues that were not known to his family and the family have since reflected that this early trauma may have been a significant contributory factor for his protracted substance misuse.

A report in 2019 by a Chid Sexual Abuse support Charity[19] identified that people who had experienced child sexual abuse reported mental health issues and drug and alcohol misuse.

"*self-medicating with drugs and alcohol can be seen as a life-saving strategy by people who have experienced CSA to regulate emotions, either by numbing the pain or promoting euphoria and a feeling of aliveness*".

7.3 A review of this case by the health and care trust identified that initial allegations of sexual abuse could be more effectively dealt with by those receiving them to ensure that the person making the allegation feels heard and supported. If the person declines support initially there should be some form of follow up. It is recognised that some professionals see this as a difficult area and are unsure on what the response to the person should be where there is an allegation made. It is felt that this is an area which would benefit from some easy-to-follow guidance and signposting for professionals.

[18] Section 5 of the Mental Capacity Act clarifies that where a person is providing care or treatment for someone who lacks capacity then the person can provide the care without incurring legal liability.
[19] One in Four (2019) Numbing the Pain: Survivors' Voices of Childhood Sexual Abuse and Addiction. London: One in Four.

Recommendation 6
The Worcestershire Safeguarding Adults Board should consider whether there is appropriate guidance and support available for professionals who may receive allegations of historic child sexual abuse.

7.4 There were a number of occasions where police attended incidents and officers reported a safeguarding concern to the police Harm Assessment Unit (HAU). This appears to be in accordance with the procedural guidance and toolkit delivered to officer and staff.[20] The HAU did not then, in appropriate cases make onward referrals to ASC. Whilst it is the role of the HAU to triage information from officers the cumulative effect of information being received should be taken into account as should the history of the particular case. There were also instances where Safeguarding referrals were not made by police officers due to the fact that medical professionals were also involved. During the discussion event for this case it was stated that this was the procedure for police, as the expectation was that health professionals would make the referral. It would seem that this procedure requires more explanation across the safeguarding partnership to ensure that areas of concern do not fall through the gaps.

7.5 There were occasions in this review where agencies would did not attend John's address as there had been previous information regarding him possessing weapons or firearms. There were also agencies involved with John who were in regular contact with him but were not aware of the potential risk of weapons being present at his address.

Recommendation 7
West Mercia Police should review the process of safeguarding referrals being passed to the HAU to ensure the appropriate action is taken and review the process of making safeguarding referrals where health professionals are involved to ensure the process is clearly understood by all parties.

Recommendation 8
Any agency which becomes aware of a specific risk presented by a person they are delivering services to, should consider the needs to make other agencies appropriately aware of that potential risk. This should be promoted by the WSAB.

8.0 Conclusion

8.1 There is evidence of good support being afforded to John at various times and this is recognised by his family. There is also evidence that procedures that had were in place at the time would have assisted in coordinating this support. The existing self-neglect procedure has been reviewed and this has been complemented by the CARM policy. The safeguarding partnership now need to ensure that these are appropriately used by making them a local priority.

[20] West Mercia Police, Adult Safeguarding – A Procedural Introduction and Toolkit for Officers and Staff

8.2 John was a long-term abuser of alcohol and other substances. His engagement fluctuated and at times he made it difficult for those wishing to support him. There is clear evidence that the Blue Light Project made a difference for John and in turn lifted the burden that he posed to agencies with repeated contact. There needs to be a discussion locally to establish if the Blue Light or a similar project can be funded and sustained.

8.3 This is not the first case in Worcestershire or elsewhere where a person's propensity to abuse alcohol or other substances does not allow them to access secondary mental health. There needs to be a local discussion as to how this gap might be addressed.

9.0 Recommendations

Recommendation 1

The Worcestershire Safeguarding Adults Board should when developing Board priorities consider the promotion of understanding and dealing self-neglect and the refreshed policy.

Recommendation 2

The Worcestershire Safeguarding Adults Board should monitor the progress of the use of the self-neglect and Complex Adults Risk Management framework. This should include the introducing the role of CARM coordinator and consideration of piloting regular CARM/self-neglect management meetings.

Recommendation 3

Commissioners of mental health and substance misuse services in Worcestershire should consider how secondary mental health services and substance misuse services can work together to provide a service to those persons with co -occurring conditions.

Recommendation 4

The Worcestershire Safeguarding Adults Board should initiate discussions to establish what the future of the Blue Light Project is in Worcestershire.

Recommendation 5

Agencies should explore and record with a person at the time of initial contact what their preference on methods of future contact are.

Recommendation 6

The Worcestershire Safeguarding Adults Board should consider whether there is appropriate guidance and support available for professionals who may receive allegations of historic child sexual abuse.

Recommendation 7

West Mercia Police should review the process of safeguarding referrals being passed to the HAU to ensure the appropriate action is taken and review the process of making safeguarding referrals where health professionals are involved to ensure the process is clearly understood by all parties.

Recommendation 8

Any agency which becomes aware of a specific risk presented by a person they are delivering services to, should consider the needs to make other agencies appropriately aware of that potential risk. This should be promoted by the WSAB.

Appendix A –

Rapid Review SAR – Worcester Safeguarding Adult Board – John

Terms of Reference

BACKGROUND

A Safeguarding Adult Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

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

the adult has died, and

the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

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

CIRCUMSTANCES

The subject of this review is John
John had a significant history with a number of agencies. Between 2007 and March 2022 John attended hospital emergency department on 167 occasions and was admitted on 36. Many of these attendances were for overdoses of medication.
John had a history of substance misuse (alcohol) and services were involved with him to support him with this.
John had mental health issues (anxiety and depression) and over a protracted period there were concerns regarding him self-neglecting and hoarding behaviour at his address.
Both John's parents passed away (mother 2015 and father January 2022), these events impacted on him, particularly the death of his father.
There had been information that John was in possession of firearms and offensive weapons and this impacted on the way in which services were able to attend incidents reported at John's address.
In March 2022, ambulance reported attending John's address following a call from a friend of John that he had been found unresponsive in his flat. Ambulance staff found John dead on the floor of the address, with evidence of drug paraphernalia around him.

METHODOLOGY

This review will build on the scoping from the rapid review process and use the basis of this case to better understand what are seen as repeating themes within the partnership. This will be conducted by using this case for a strategic workshop to address the partnership areas of consideration below.

CHRONOLOGIES PROVIDED BY:

1. **Worcester County Council Adult Social Care (WCC ASC)**
2. **Hereford and Worcester Health and Care NHS Trust (HWHCT)**
3. **Herefordshire and Worcestershire on behalf of Primary Care**
4. **National Probation Service (NPS)**
5. **Worcestershire Acute Hospital NHS Trust (WAHT)**
6. **West Mercia Police (WMP)**
7. **West Midlands Ambulance Service (WMAS)**
8. **Hereford and Worcester Fire and Rescue Service (HWFRS)**
9. **Advance Housing and Support**
10. **Maggs Day Centre**
11. **Cranstoun**
12. **Worcester City Council Housing**
13. **Rooftop Housing Group**

TERMS OF REFERENCE

Areas of consideration

Case specific

1) Was self-neglect and hoarding identified and what action was taken to address these issues?

2) What policies and procedures were in place at the time, were they effectively used and if not, what were the barriers to this?

3) What services were involved with John and was the action taken by them coordinated and complimentary?

4) What services were available to support John with substance misuse/mental health/physical health? How did they manage any disengagement?

5) Were there safeguarding concerns / fluctuating capacity issues, if so, were they appropriately identified and addressed?

6) How was the risk of firearms and offensive weapon possession managed and was information shared effectively to facilitate risk assessment?

7) What was the impact of Covid on John and services he received? What was the impact on those services delivering them?

Partnership specific

8) What was the impact of the reduction of the Blue Light Project?

9) How would the revised self-neglect policy and CARM process have impacted on this case? How well understood are the processes?

TIMESCALE

The review will focus on the period 1st May 2018 to the date of John's death 18th March 2022.

SIGNIFICANT PERSONS

Relevant family members, and any other important personal network will be informed what the Safeguarding Adult Review is for, how it will work, what the parameters are and how they can engage in the review.

STRATEGIC WORKSHOP

To be facilitated by Report Author. To generate learning arising from the themes present in the chronology and case.

PARALLEL PROCEEDINGS

HM Coroner is undertaking an inquest. There is ongoing communication between the Safeguarding Board and Coroner's office.

PUBLISHING

It should be noted by all agencies that the SAR report will be published once complete unless it would adversely impact on the adult or the family.

Reference to the adult in the report may be anonymised further prior to publishing. This will be following consultation with the adult/family and time allowed to reflect on how they would like the adult to be referred to.

Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware in advance of the intended publishing date

Whenever appropriate an 'Easy Read' version of the report will be published.