Swindon Safeguarding Partnership
Executive Summary
Safeguarding Adult Review – Brian

Introduction

Brian was a 43-year-old white British man who had mental health needs and a history of drug use. He lived alone in a flat, where he died in a fire on 7th February 2022. From July 2020 until his death, Brian was in contact with several agencies including the police, the ambulance service, mental and physical health services, and specialist drug services in response to self-neglect and drug dependency. Agencies struggled to engage with Brian who spent periods of time away from his flat, staying in hotels.

Brian had mental health needs and a long history of poly-substance misuse, particularly heroin and cannabis, with alcohol misuse also noted. He had continued to use drugs and alcohol while also taking methadone. Brian had been in prison on several times.

Brian was considered by Avon and Wiltshire Mental Health Partnership Trust (AWP) to be at risk of harming himself from misadventure if his mental health presentation deteriorated. Drug use was found to worsen his mental health and increase his delusional paranoid thoughts.

In 2020 Brian was diagnosed with autism spectrum disorder (ASD). He presented at this time with some ongoing depressive symptoms and was involved with probation services.

Conclusions

There was no co-ordinated multi-agency response to Brian's needs.

Despite the number of agencies involved with Brian, no multi-agency meetings were held. These could have enabled all the agencies to pool their knowledge of Brian. This may have resulted in the generation of new and co-ordinated approaches to engage with Brian and to meet his complex needs. (See Finding 6)

The Police contacted the SIS shortly before Brian's death to suggest a multi-agency approach be taken to working with Brian. Other events which might have triggered a multi-agency approach, such as safeguarding concerns and GWH's high intensity user letter, did not prompt such a response. The self-neglect pathway, which may also have brought agencies together, was not considered.

There were reports of individual agencies communicating with each other, but knowledge sharing was fragmented in places, so no one had a full picture of Brian. No one took on case leadership for instigating joined-up multi-agency inventions. The lack of a multi-agency approach is significant because it appears that no single agency had sufficient knowledge and understanding of Brian to meet his complex needs.

Understanding of circumstances which may be predictive of poor outcomes and using these to inform practice

Brian, and the response of services to him, shared most of the characteristics with the cases identified in the Alcohol Change UK July 2019 report, and the Stoke and Staffordshire "Andrew" SAR.

This pattern of circumstances might be predictive of poor outcomes. In consequence, services should consider how the presence of this pattern of characteristics might be identified in the future and how this might lead to interventions that result in better outcomes. (See Finding 1)

While the Great Western Hospital had identified that Brian was potentially at high risk due to his frequent Emergency Department attendances and was a high intensity user, this does not appear to have led to different responses by agencies or to a co-ordinated multi-agency response.

There was little exploration of the effects of traumatic events on Brian

Whilst practitioners believed that Brian has been adversely affected by the death of his mother in 2019, there seems to have been little exploration of events in Brian's life prior to 2019. Brian started taking drugs and misusing alcohol well before then, he first became involved with mental health services around 2010/11 presenting with anxiety and depression from the age of 18 he was described as having obsessive compulsive disorder traits and at some point he was diagnosed with PTSD. There appears to be no exploration of what the trauma was and the extent to which it affected Brian. There was no exploration of Brian's life history and what had led to his excessive use of alcohol and drugs. Brian's sister contacted Brian's Care Coordinator in January 2021 concerned that Brian needed more support, and this may have been an opportunity to have gathered some history. (See Finding 2)

There was little or no operational realisation of Brian's diagnosis of ASD

The ASD team were commissioned only to diagnose ASD. There were no specialist ongoing treatment services for people with ASD currently commissioned in Swindon.

There was no consideration of how Brian's autism and mental health concerns could be managed in tandem, nor indeed consideration of how best to support someone with a triple diagnosis of ASD, mental health needs and substance dependency.

Although GWH were aware of Brian's ASD diagnosis, apart from AWP, no other services appear to have been made aware of it. This would have been a barrier to considering how they might have responded to Brian in a way which took account of

his needs. It also meant that other agencies would not have taken account of ASD in considering Brian's capacity to make decisions. (See Finding 3)

Risk assessments

AWP completed risk assessments, but they did not consider how risk fluctuated depending on circumstances (such as substance intoxication) and how occasions of heightened risk could be mitigated. During the risk assessment conducted by AWP in January 2021 specific examples of risk which were rated in the risk assessment as "high" risk, yet these did not appear to have been translated into any action plan.

The risk of suicide did not lead to a safety plan

Brian had a history of self-harming and presenting as suicidal. Brian had a history of overdose dating back to 1990. In the last five months of Brian's life he took an overdose and on at least two separate occasions presented as suicidal. The Royal College of Psychiatrists recommends a safety plan for "*any patient with suicidal thoughts or following self-harm".*

The development of a safety plan in conjunction with Brian, may have served to explore Brian's thoughts in more detail and have provided strategies for Brian to cope with suicidal thoughts. Given what is known about the rapidity with which suicidal intention can turn into suicidal acts, it would have been appropriate for safety plan to have been drawn up as a contingency. (See Finding 4)

Staff understanding of hoarding could be improved

The reports of the level of hoarding in Brian's flat before and after the fire are inconsistent and suggest that the understanding and recognition of hoarding and of the need for intervention may need to be improved.

There was an over-reliance on AWP for all care needs

The safeguarding team regarded the contents of the safeguarding concern raised by Turning Point as indicating that Brian's mental health was deteriorating and consequently referred him back to AWP. The emphasis of the safeguarding referral on mental health did not seem to recognise that psychiatric interventions may not produce an immediate improvement in Brian's mental health, and consequently on his motivation to self-care and do house-work. Nor did it recognise that Brian may not have been physically able to look after himself because of the fracture to his hip.

Recognition that Brian had a complex array of needs including mobility issues at that time may have led to a care and support needs assessment.

The effect of long-term substance dependency on mental capacity was not understood or was not applied.

It appears that practitioners were unaware that people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening. This understanding was not applied in assessing Brian's mental capacity. (See Finding 5)

Effective practice for working with people who self-neglect

Some of the key components of effective practice with people who self-neglect were either not applied or were applied insufficiently (See Finding 5).

The following are provisional depending on receipt of further information:

Findings

The Swindon Safeguarding Partnership askes that findings, rather than recommendations, be presented for it to base actions on.

Finding 1: Brian presented several of the characteristics identified in the Alcohol Change UK 2019 report and the Stoke and Staffordshire "Andrew" SAR.

Finding 2: There is no training module on trauma informed practice with adults, particularly with people who use substances and self-neglect.

Finding 3: Multi-agency approaches were not used and information was not always shared and when it was, such as when Brian was identified by GWH as a high intensity user, this did not influence approaches to him.

Finding 4: Suicide safety plans, as recommended by the Royal College of Psychiatrists for "any patient with suicidal thoughts or following self-harm", were not used for Brian.

Finding 5: There is no framework for practice in complex cases. Such a framework might be useful to guidance practice where there are dual and even triple diagnoses and self-neglect