Swindon Safeguarding Partnership

Safeguarding Adult Review
Robert January 2023

Date Completed: 6 March 2024
Parminder Sahota
Independent Author and Chair

Contents

Preface

To ensure confidentiality, only the Reviewer/Author and review panel's names have been disclosed; all other names are pseudonyms.

The Independent Reviewer and Review Panel would like to express their sincere condolences to everyone impacted by Robert's passing and thank them for their support and contributions to this process.

A Safeguarding Adult Review (SAR) is a multi-agency statutory review designed to determine what the relevant agencies and individuals involved may have done differently to avert harm or death. For these lessons to be widely and correctly learned, it is necessary to determine what may be known from each person's death and for agencies to understand what happened in each case.

The Reviewer wishes to thank the panel and individuals who provided chronologies and material for their time, patience, and cooperation.

The Reviewer expresses gratitude to Michelle, Robert’s long-term partner, who assisted with the review to ensure that it appropriately portrayed Robert’s life.

Section One: The Review Process

1.1 Introduction and Agencies participating in the review process

1.1.1 The summary describes the measures undertaken by the Swindon Safeguarding Partnership to review the death of one of its residents in January 2023.

1.1.2 The review commenced due to Robert's death in January 2023. The Integrated Care Board (ICB) of NHS Bath and Northeast Somerset, Swindon, and Wilshire informed Swindon Safeguarding Partnership of the death on 25 April 2023. Robert met the requirements of the Safeguarding Adult Review (SAR).

1.1.3 The notification identified the following characteristics: Mental Health, Alcohol abuse, Serious Illness and Self-Neglect.

1.1.4 The review was conducted thematically. It incorporated a synopsis of the principal themes derived from four recently concluded SARs in Swindon, considering the themes that arise from the present SAR in conjunction with previously published reviews and research at the national level.

1.1.5 At the time of his death, Robert was 53 years old, a white British national who resided with Michelle, his long-time companion. He was the father of no children. Despite this, he considered Michelle's daughter his own because of the extended duration of their relationship.

1.1.6 Michelle observed that the transition from the workplace to home during COVID-19 was not well received by Robert, who had previously enjoyed commuting. Michelle asserted that Robert's subsequent doubts over his capability to carry out his responsibilities were unwarranted.

1.1.7 Robert started consuming an excessive amount of alcohol in August 2022, and this escalated in October 2022, which made him susceptible to falls.

1.1.8 The South Western Ambulance Service NHS Foundation Trust (SWAST) responded to two calls at Robert's home in December 2022 due to falls.

1.1.9 Three weeks before Robert's death, SWAST attended his home and observed that he was intoxicated and had sustained numerous face injuries as a consequence of prior falls. A carpet burn and an open cut on his face, an abrasion to his nose, and a golf-sized nodule on his forehead. Robert expressed his wish to die.

1.1.10 Robert had engaged with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) Talking Therapies in April 2019 and reported experiencing depression and anxiety; he had no prior contact with alcohol services: Turning Point.

1.1.11 Michelle had taken respite at her sister’s home three weeks before Robert’s death and returned every three days; she confirmed they had not separated.

1.1.12 Robert’s employer visited him at home eight days before his death and informed Swindon Borough Council of a safeguarding adult concern around his self-neglect, alcohol misuse, and suicidal risk.

1.1.13 Michelle discovered the body of Robert in their home in January 2023.

1.1.14 The Safeguarding Adult Review Panel convened on 23 October 2023.

1.1.15 The panel conducted its final meeting on X.

1.1.16 The following agencies and the contributions to the review:

Agency and Profile	Contribution- Chronology/report
Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)	Chronology and Report
GP Practice	Chronology and Report
Great Western Hospitals NHS Foundation Trust (GWH)	Chronology and Report
NHS Bath and Northeast Somerset, Swindon, and Wiltshire Integrated Care Board (ICB)	Referral
South Western Ambulance Service	Chronology and Report
Swindon Borough Council, Adult Social Care (ASC)	Chronology
Turning Point	Chronology
Wiltshire Police	Chronology

1.1.17 The panel members were:

Agency	Role	Name
Avon and Wiltshire Partnership NHS Trust	Head of Safeguarding	Lynn Franklin
Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board (BSW ICB)	Designated Nurse	Robert Mills
BSW ICB	Named GP	Michelle Sharma
Great Western Hospital NHS Foundation Trust	Associate Director for Safeguarding	Wendy Johnson
NSPCC	Team Manager	Lisa Strode
Oxford Health	Senior Named Nurse Safeguarding Children	Liz Navrady-Wilson
Probation	Senior Probation Officer	Poppy Salliss
Swindon Borough Council - Adult Services	Head of Safety & Assurance	Lee Aldridge
Swindon Borough Council – Children Families & Child Health (SBC – CF&CH)	Named Nurse	Charlotte Hinder
SBC - CF&CH	Named Nurse	DeeDee Alexandre
SBC - CF&CH	Head of Quality Assurance	Fiona Francis
SBC - CF&CH	Head of Early Help, Youth and Community Services	Scott Jones
SBC - Education	Lead Safeguarding Adviser	Tanya Westall
Wiltshire Police	Practice Review Manager	Hayley Williams

1.1.18 Parminder Sahota is an independent author who has worked in Safeguarding and Domestic Abuse for eleven years. She completed Root Case Analysis Training in 2014, SCIE Learning Together Training in 2016 and DHR Reviewer training by Advocacy After Fatal Abuse in 2021. She is a Mental Health Nurse who has worked in the NHS for over 20 years, specialising in crisis work and working with persons diagnosed with a personality disorder. A National Health Service Trust employs her as the Director of Safeguarding, Prevent, and Domestic Abuse Lead.

1.1.19 Parminder Sahota is independent of all agencies involved and had no prior contact with family

1.2 Purpose and Terms of Reference

1.2.1 This review attempts to identify the lessons learned from Robert's case and the previous four SARs to respond to those lessons to prevent safeguarding-related deaths.

1.2.2 The Critical Question to be addressed by the review:

> What can agencies learn regarding the efficacy of treatment and support for persons with numerous physical and mental health needs, alcohol consumption, risk of self-neglect, and unwillingness to engage with services?

1.2.3 The Safeguarding panel agreed on the following questions regarding Robert and compared them to the prior SAR findings:

1. How was the principle of 'making safeguarding personal' achieved? Did agencies consider Robert's wishes and feelings when providing care and treatment?
2. How did agencies assess Robert's capacity, were the assessments shared, and how did this impact the care Robert received? **Findings from the Previous SARs** **a) "Alison" - How does the partnership approach the criteria in the second stage of the Mental Capacity test when assessing people?** **b) "Andrew" – How does the partnership ensure that Mental Capacity Assessments are conducted when concerns about a person's mental capacity are raised?** **c) "Brenda" - What support is in place to ensure practitioners adopt the Mental Capacity Act 2005 principles, specifically balancing risk and unwise decisions?** **d) "Brian" – How do practitioners assess risk and apply the Mental Capacity Act 2005 and the Human Rights Act 1998 (Article 2 – Right to life)?**
3. Were agency assessments and decisions carried out appropriately and promptly? Were factors such as substance and alcohol abuse and mental health assessed, and if so, what were the care plans to address these? **Findings from the Previous SARs** **a) Alison" – Is the AUDIT alcohol screening tool utilised in health and social care settings, and how does this impact the individual and organisation?** **b) "Andrew" – Are risk factors like alcohol highlighted for the individual and others? How do agencies respond to individuals who are repeatedly present while intoxicated?** **c) "Brian" – How do organisations encourage practitioners to be professionally curious and explore the underlying causes of excessive alcohol use when confronted with alcohol-using individuals?**
4. What tools are available to practitioners to identify and support those at risk for self-neglect? **Findings from the Previous SARs** **a) "Andrew" - How are health and social care agencies implementing and assessing the effectiveness of their self-neglect policy and training?** **b) "Brenda" – How do services respond to individuals at risk of self-neglect and declining support?** **c) "Brian" – What frameworks are accessible to practitioners to respond to self-neglecting individuals?**
5. Did practitioners consider multi-agency decisions into account?

1.2.4 The period under review was from August 2022 to January 2023. Michele and the panel agreed upon this period, as Robert commenced drinking at this period and sought assistance from services. The agencies that had previously contacted Robert provided a summary.

Section Two Agency Contact

Avon and Wiltshire Mental Health Partnership NHS Trust

2.1.1 Following his A&E presentation to GWH in August 2022, Robert was referred to AWP; upon his assessment at GWH, the staff concluded that his episode was due to alcohol consumption rather than ill mental health, and he was subsequently discharged.

2.1.2 Robert was assessed in GWH in September 2022; Michelle discovered him intoxicated and a rope dangling from the loft opening. According to Robert, this was not a suicide attempt. Michelle feared for his well-being if he returned home. AWP confirmed that Robert had been referred to Talking Therapies and Turning Point and that his GP had been asked to review his mental and physical health.

2.1.3 Two days later, when Robert was reviewed in A&E GWH, he revealed experiencing suicidal thoughts and having fashioned a rope in the loft from which he put his head while consuming wine. He was discovered on the floor by his partner. Robert was admitted to GWH. The following day, Robert was referred to the Swindon Intensive Support (SIS) Home Treatment Team.

2.1.4 SIS completed an assessment in Robert's home with Michelle present. During the assessment, Robert disclosed experiencing anxiety and guilt, attributing personal shortcomings to himself. Although he refrained from revealing his alcohol intake, he did indicate that reducing this would provide him with access to support resources, such as counselling. SIS discharged Robert to his GP.

2.1.5 Upon calling 111, Robert was connected with the AWP Primary Care Liaison Service. He expressed experiencing anxiety and a desire to engage in conversation. In twelve days, he stated he had an appointment with a mental health nurse at his GP Practice.

2.1.6 Robert was referred to GWH in January 2023 after he fell while intoxicated. Robert declined AWP's referral, and the A&E Consultant ascertained that he had the capacity to make the decision; AWP did not see him.

2.1.7 The police contacted SIS the next day; Michelle had denied Robert entry to the home, and Robert climbed in through a window. The Liaison and Diversion Service assessed Robert at the station. He was scheduled to meet with SIS the subsequent day. However, Robert declined and stated he was staying in a hostel as Michelle did not want him to return home. Michelle confirmed Robert had never stayed in a hostel.

2.1.8 Swindon Borough Council notified AWP of the safeguarding Referral by Roberts's employer.

GP Practice

2.1.9 Robert communicated his diminished appetite to the Practice. He revealed that he was experiencing anxiety and excessive alcohol consumption and that he wished to modify his drinking patterns. Information about Alcoholics Anonymous (AA) was supplied to him.

2.1.10 Robert was signed off work in August 2022 and, at his request, commenced on anti-depressants and urged to reduce his alcohol use.

2.1.11 Robert disclosed to his GP later that month that he had been admitted to the hospital as a result of excessive cannabis oil usage for sleep aid purposes. He resumed employment, commenced antidepressant medication, and was prescribed detoxification medicine. He declared that he had ceased consuming alcoholic beverages.

2.1.12 The GP was informed of Robert's presentations to GWH. Robert was signed off from work in September 2022.

2.1.13 Robert did not attend two GP Appointments.

2.1.14 Robert disclosed his hospital discharge over the weekend to his GP and requested antidepressants due to his reliance on alcohol as a coping mechanism. He stated that he had engaged with Turning Point and maintained a two-week abstinence from alcohol. His partner and her daughter, he reported, were supportive.

2.1.15 Robert informed his GP in November 2022 that he had abstained from alcohol and consumed two meals daily; his mood was low, and he lacked motivation.

2.1.16 Robert informed his GP in December 2022 that he was engaging in AA meetings and had not used alcohol in two weeks. His mood remained low, and he was preoccupied with past errors. He disclosed experiencing work-related stress, had a supportive partner, and gave informed consent to engage with Talking Therapies and augment his antidepressant dosage. His GP recorded that he posed a risk of intentional self-harm.

2.1.17 Robert requested a sick note in December 2022 on account of exacerbating anxiety and depression, which prevented him from returning to work.

2.1.18 As the GP had not seen Robert, as all previous contacts had been by phone, she presented the Practice with an image of Robert afflicted with various injuries; Michelle sought a home visit. Robert was not attending to his hygiene. He was abstaining from food and drink and instead consuming alcohol. It was recommended to Michelle that Robert attend the practice. The practice concurred that a home visit ought to have been performed.

Great Western Hospital NHS Foundation Trust

2.1.19 Due to falls caused by excessive alcohol consumption, Robert was seen in GWH. On separate occasions, he had self-inflicted harm by cutting, cannabis oil medication overdose, and contemplation of suicide.

2.1.20 Michelle informed GWH of her concerns and said she found managing Robert challenging.

2.1.21 In October 2022, Robert was admitted for sixteen days at GWH; he received treatment for pneumonia and was placed on an alcohol detoxification programme.

2.1.22 On an A&E visit in December 2022, GWH saw that Robert had numerous open wounds on his face, some of which seemed to be healing; he denied being intoxicated before these falls.

2.1.23 GWH notified Robert's GP Practice via a high-intensity user letter dated January 2023 that he had visited A&E six times over the previous twelve months.

Police

2.1.24 The police made contact with Robert and Michelle in September 2022. It was stated that Michelle had pushed Robert, causing him to fall to the ground. She reported Robert's drinking to the police, which was straining their relationship; she had pushed him out of frustration about the consequences of his intoxication. Michelle spent the night at her daughter's home.

2.1.25 Michelle called the police because she was having a difficult time dealing with Robert, whom she reported to be an alcoholic and wanted him removed from the home. The police stated this was a civil matter. She declared that she was emotionally exhausted from providing him with ongoing care owing to his degree of intoxication. She disclosed to the police that Robert had been consuming alcohol since August 2022 and had attempted suicide by self-harm.

2.1.26 Robert had entered the home via the window, prompting Michelle to call the police. Robert was arrested to avert a breach of peace.

South Western Ambulance Service NHS Foundation Trust

2.1.27 SWAST attended Robert's home following the attempts to end his life in August and September 2022.

2.1.28 SWAST attended Robert's home in December 2022; he sustained nose and ear injuries as a result of a fall. He reportedly had alcoholism and fell three to four times daily. Robert refused to report to the hospital.

2.1.29 In December 2022, SWAST was dispatched once more; Robert had sustained a head injury due to a fall and had also ingested an excessive amount of medication. He was noted to have many facial injuries. He was transported to hospital.

2.1.30 SWAST attended Robert's home in January 2023; he was intoxicated and expressed his desire to die to Michelle. Robert requested a knife from the paramedic to end his life. He was subsequently brought to the hospital.

Turning Point

2.1.31 In August 2022, Turning Point received a referral for Robert, and an assessment was scheduled for October 2022. Robert cancelled this scheduled appointment due to his hospitalisation. Turning Point sent Robert a letter in November 2022 urging him to make contact lest his case be closed. The case was closed following no contact in November 2022.

2.1.32 AWP Referred Robert to Turning Point in January 2023. According to the referral, Robert's alcohol dependence had deteriorated significantly during the preceding eighteen months, and he had encountered heightened suicidal ideation when under the influence. The referral said that he consumed multiple beers regularly and was experiencing mild withdrawal symptoms.

2.1.33 Two days before Robert died, he cancelled his appointment with Turning Point.

Section Three: Themes

3.1.1 **Making Safeguarding Personal and Professional Curiosity.**

3.1.2 AWP and GWH concluded that their assessments were person-centred and focused on Robert's wishes. There was documentation in his records, which sought to seek his views and wishes. However, the reviewer determined that the balance of risk and autonomy was not considered. In addition, each occurrence was reviewed separately, and his prior presentation of the services needed to be considered.

3.1.3 Robert had declined assessments by Turning Point and AWP. The principle of making an 'unwise decision' is enshrined in the Mental Capacity Act 2005. However, this should also involve a discussion of the rationales behind declining services and pursuing professional curiosity.

3.1.4 Robert was not referred to ASC for a Care Act Assessment by any agencies he interacted with.

3.1.5 **Alcohol and Safeguarding**

3.1.6 Robert's presentation to AWP and GWH was related to alcohol; no documentation concerning self-neglect was produced during these presentations. Michelle presented images to Robert's GP to illustrate his severe weight loss and facial bruising caused by falls. She reported receiving guidance to inform Robert to attend the practice. The GP practice could not confirm why this guidance was given, and Robert was not seen face-to-face. Michelle forwarded these photographs to the reviewer, who subsequently forwarded them to the panel to comprehend Robert's decline better.

3.1.7 The ambulance services attended Robert's home and observed him to be intoxicated and multiple bruises to his face. Additionally, GWH observed multiple healed and open wounds on his face.

3.1.8 Robert was at risk of self-neglect. The previous SARS in Swindon, 'Alison,' 'Andrew,' and 'Brian' raised concerns about the agency's responses to dependent drinkers, noting that neither alcohol screening assessments nor professional curiosity were used.

3.1.9 The practitioner workshop brought to light the probable unconscious bias of those who exhibit signs of intoxication as a lifestyle choice; such an assumption prevents a more in-depth examination and comprehension of the underlying causes of the drinking.

3.1.10 No services raised a safeguarding concern or requested a Care Act Assessment.

3.1.11 **Legal Literacy**

3.1.12 The Care Act 2014 specifies that the Local Authority has a duty to make enquiries or cause others to do so if they suspect an adult is experiencing or is at risk of abuse or neglect, including self-neglect.

3.1.13 Those who suffer from mental impairments due to the consumption of alcohol or drugs are acknowledged and governed by the Mental Capacity Act of 2005. Addictive behaviour can supersede an individual's knowledge comprehension and suggest a capacity deficiency. Including executive capacity in assessments and an individual's capability to process and evaluate information is crucial.

3.1.14 **Alcohol Dependence and Mental Health**

3.1.15 The three Swindon SARs underscored the necessity for services to emphasise risk factors, such as alcohol consumption, and to be professionally curious about the root causes of excessive alcohol use.

3.1.16 Robert revealed that he ruminated on past mistakes, which led him to resort to drinking as a coping mechanism. Robert did not use the talking therapy contact information that the GP offered. The agency's documentation did not highlight what the 'mistakes' were.

3.1.27 In October 2022, Michelle told AWP that Robert had not engaged with Turning Point. They reported that she would be speaking to her GP. This was an opportunity to ask Michelle how she was coping and whether she needed support. Robert disclosed to his GP in December 2022 that he was not participating in AA. No action was taken as a result of this. Robert requested a second statement to sign him off from work in late December 2022 since he had felt anxious and depressed since returning to work.

3.1.28 Michelle went to Robert's GP Practice with photos of Robert and a request for him to be seen instead of providing the fit notes. Michelle stated she was denied her request.

3.1.29 The practitioner workshop emphasised that a considerable number of the individuals they encounter are averse to attending Turning Point Due to numerous factors, including the location and the social stigma associated with it.

3.1.30 It was reported that Robert underwent detoxification after his three weeks of admission to GWH; this would have been an ideal opportunity to support his engagement with alcohol services and gain a deeper understanding of the causes of his excessive drinking to facilitate a safe discharge and community support.

3.1.31 **Self-Neglect**

3.1.32 Self-neglect was not reported by any agencies who engaged with Robert. The reviewer enquired whether Robert's appearance had been reported to the agencies that observed him. This occurred solely in the ambulance service's log. Michelle's photographs unequivocally depict Robert sustaining multiple facial injuries and experiencing significant weight loss. As a result, the reviewer would have anticipated that the agencies that observed him would have reported a safeguarding adult concern. A Safeguarding concern was brought to ASC's attention by his employer.

3.1.33 **Multi-Agency Working**

3.1.34 Although information was communicated to the GP, there was no coordinated response in the agency records.

3.1.35 **Think Family**

3.1.36 Michelle had informed Robert's GP, AWP, GWH, the police, and the ambulance of her concerns for Robert and her difficulty managing them.

3.1.37 Robert informed AWP of his supporting partner that his mental health deteriorated when Michelle left the home; this was shared with the GP. No interventions were implemented for Michelle or Robert when Michelle left the house.

Section Four: Recommendations

Individual Agency Lessons Learnt/Key Findings

4.1.1 Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

1) Practitioners should raise awareness of and use more professional curiosity about risks and safeguarding matters when conducting risk assessments.
2) More routine application of the Mental Capacity Act 2005 to identify trigger points to conduct formal mental capacity assessments and document these as set out in AWP trust guidance.
3) Increased use of multi-agency professionals' meetings in cases complicated by challenging engagement, lack of consent, multiple interrelated comorbidities requiring multi-agency input, etc.
4) AWP practitioners were already instructed in an alert that cases involving self-neglect should automatically be brought to the AWP Safeguarding Team for consideration and advice; this review identifies the need to be reviewed.
5) To consider including an individual's employer as a partner agency in terms of triangulating support and risk management
6) Access Services, AWP, and CGL have organised meetings to discuss complex cases. (Please confirm when the meeting began and the frequency of the meeting).

4.1.2 GP Practice

1) Each time that alcohol/depression is mentioned, the extent of the issue should be explored, the proper support offered, and all of this should be documented thoroughly. The Named GP for safeguarding will reiterate this learning with the surgeries in Swindon. The patient consistently asked for support for his drinking from the surgery and was aware of the help and support that was available and had said that he was accessing this.

4.1.3 Great Western Hospitals NHS Foundation Trust (GWH)

1) Within an emergency department, an assessment of capacity is often worded as "I believe looking at the balance of probabilities that this person has/cannot make this decision because..." alongside a recording of the outcome of the decision. It may have been helpful if clinicians had recorded something similar to this in each presentation to the Trust.
2) A Trauma-informed approach to emergency department practice could be beneficial for patients presenting with mental health distress.
3) Referrals to other agencies (such as alcohol liaisons) should be recorded on each relevant occasion.
4) The Trust needs to strengthen the self-neglect resources on the Intranet.

4.1.4 Multi-Agency Recommendations

Every organisation must ensure that safeguarding remains a subject of supervision and must retain accountability for overseeing complex safeguarding cases.

4.1.5 Recommendation One: Making Safeguarding Personal and Professional Curiosity

4.1.6 The Care Act 2014 guidance stipulates that adult safeguarding practice must be person-centred and outcome-focused, with MSP as the recommended safeguarding strategy alongside the other six safeguarding principles. Professional curiosity consists of attentively listening to a person's story without passing judgment or making

assumptions. Robert declined support even though it was apparent he was struggling to control his drinking, as evidenced by the photographs, which revealed he was not eating, suffering from severe injuries sustained from falls, and was unable to sleep or attend to his care, as reported by Michelle.

1.a Swindon Safeguarding Partnership will examine its MSP strategy and MSP outcomes via data returns and request confirmation that agencies take advocacy into account.

1.b The partnership will provide partners with Professional Curiosity training and undertake evaluations three and six months following participation.

1.c Swindon Safeguarding Partnership should review its escalation procedures to ascertain partners' confidence in implementing its escalation procedures. Processes to support practitioners when service users decline assistance and are at high risk of harm should be incorporated into the procedures.

1.d Senior management must support and invest in implementing trauma-informed strategies within organisations. The leadership group formulates the organisational trauma-informed strategy. This will necessitate establishing a secure environment, clinical and non-clinical staff education, and patient participation.

1.e Organisations that are part of the Swindon Safeguarding Partnership are responsible for ensuring that their information-sharing practices adhere to legislation and the Caldicott principles

I. Care Act 2014 Chapter 14 Paragraph 43: Early information sharing is critical to effectively responding to emerging concerns.

II. GDPR allows the sharing of information without consent where there is a need to safeguard children and individuals at risk

1.f Change Grow Live (CGL) to continue to attend partnership meetings and complete audits as requested.

1.g CGL staff to comply with all mandatory training within CGL policies.

1.h CGL staff to be encouraged to attend local adult safeguarding training in line with their job role

1. I The lead nurse, TLs x 6, and DSM will attend TiP training for managers by the end of March 2024.

1.j Review localised agreements with Adult Social Care around information sharing.

4.1.7 **Recommendation Two: Alcohol and Safeguarding**

2.a Swindon Safeguarding Partnership is tasked with developing guidance to assist agencies in comprehending the correlation between alcohol and safeguarding. All partners, including CGL, must sign and consent to the guidance before implementing the agency's policies and procedures.

2.b Swindon Safeguarding Partnership is responsible for conducting routine audits of safeguarding adult cases involving alcohol.

2.c To enhance the understanding of the relationship between alcohol-related risks and self-neglect, organisations a screening tool is necessary. With the assistance of partner organisations and in collaboration with Adult Social Care Safeguarding and Change, Grow Live, the screening tool will be created. Swindon Partnership to understand the alcohol-related risks and self-neglect, organisational screening tool.

4.1.8 **Recommendation Three: Legal Literacy**

3.a Swindon Safeguarding Partnership members to ensure that practitioners receive Mental Capacity Act training that emphasises the principle of "unwise decisions" and requires a reasonable and proportionate response. Regular reviews of such instances by senior management ensure that frontline practitioners can access necessary support.

3.b In collaboration with Change Grow Live, the Swindon Safeguarding Partnership will raise awareness among system-wide practitioners regarding the impact of mental capacity and executive functioning on dependent drinkers.

3.c The application of the Mental Capacity Act and safeguarding powers for dependent drinkers must be subject to a system-wide assessment.

3.d CGL staff to have updated input from local Safeguarding training and shadowing of core staff from other agencies like AWP to support knowledge building (AWP staff to attend CGL weekly from Mar 24, completing joint assessments and offering team learning and attend one multi-disciplinary meeting and be available for the Dual Diagnosis monthly Supervision)

3.e CGL to be part of the continual development of pathways within the system-wide assessment of cases.

4.1.9 **Recommendation Four: Alcohol Dependence and Mental Health**

CGL attends meetings and forums to support partnership, working around cases and sharing clinical knowledge. (MDTs for cases, clinical input to local providers, offering training to partners, holding a monthly coffee morning to build links, consultation with GWH on cases, liaison with housing and other agencies as requested.)

4.a CGL will work with commissioners around what support locally they can provide to support the partnership.

4.b The partnership will strengthen and review referral pathways to Change Grow Live.

4.1.10 **Recommendation Five: Self Neglect**

5.a Swindon Safeguarding Partnership will receive assurance from its members in effectively communicating and implementing the Self-Neglect Policy and Guidance. Furthermore, the policy and guidance on self-neglect should encompass provisions for resources that assist practitioners in addressing the interplay between alcohol use and self-neglect.

5.b Swindon Safeguarding Partnership to seek assurance that single agency training includes the policy and guidance.

5.c The Swindon Safeguarding Partnership will create a flowchart to assist practitioners in determining when to report a safeguarding issue involving self-neglect.

5.d CGL will continue working with local partners to develop and improve local joint working and implementation of policies.

5.f CGL to engage with staff training for self-neglect from local partnership.

4.1.11 **Recommendation Six: Multi-Agency Working**

CGL is implementing a new service called SSOS (Swindon supra outreach service), which will support a cohort of SU with the team around the person approach starting on Feb 24. Local partnership agreements are being set, and MDTs to support cases of SU's who are homeless or at risk of homelessness.

6.a Swindon Safeguarding Partnership to consider reinstating the Risk Enablement and Positive Risk Taking Panel. Structures of meetings to be meaningful with relevant participant attendance set up in advance to agree on key stakeholders' attendance

6.b Ensure that agency safeguarding policies emphasise and direct professionals' need to convene professional meetings to discuss complex cases.

4.1.12 **Recommendation Seven: Think Family**

CGL offer families a service within a group setting to enable them to be given key support; a detailed list of local and national providers of support for families is shared with families by workers

7.a Swindon Safeguarding Partnership to receive assurance from agencies of implementing the "think family" strategy.

7.b It is mandatory for all agencies who provide care and support to adults to offer carer's assessments and submit an audit to the Swindon Safeguarding Partnership for assurance.

7.c CGL will share information with the partnership and continue to enhance the awareness of Swindon residents.

Section Five: Conclusion

5.1.1 Robert saw a swift deterioration in both his mental and physical well-being from August 2022 until his death. He presented to GWH on several occasions. GWH acknowledged this and sent information to his GP. However, no actions were taken following this.

5.1.2 His presentations to GWH did not result in the use of an alcohol screening tool, and there are no records indicating that alcohol services reviewed him while he was hospitalised.

5.1.3 Each agency considered the current presentation in isolation. Michelle had voiced her worries; nevertheless, she did not obtain any assistance, and there were no subsequent recommendations for Robert to undergo a Care Act Assessment.