SAFEGUARDING ADULT REVIEW INTO THE DEATH OF ROBERT IN JANUARY 2023

Parminder Sahota: Independent Reviewer

MARCH 6, 2024

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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 thanks 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.

1.0 Introduction

1.1.1 The review was initiated in response to the death of Robert in January 2023. The NHS Bath and Northeast Somerset, Swindon, and Wilshire Integrated Care Board (ICB) notified the Swindon Safeguarding Partnership of the death on 25 April 2023. Robert satisfied the Safeguarding Adult Review (SAR) criteria.

1.1.2 According to Section 44 of the Care Act 2014, a Safeguarding Adults Board (SAB) has a statutory duty to organise a SAR when:

a) 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.
b) And when there is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

Board members must work with and contribute to the SAR to identify lessons learned and ensure they are shared and used in the future.[1]

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

1.1.4 The review will serve as a thematic review. It will include a summary of the key themes from four recently completed SARs in Swindon, considering the themes that emerge from this SAR and from previously published reviews and national research.

1.1.5 The Reviewer considered the six principles of safeguarding adults[2]:

Empowerment:	To understand how Robert was encouraged to participate in his care and make independent decisions.
Prevention:	The learning gained will be applied to prevent future harm to others.
Proportionality:	Agencies to determine if the services offered to Robert are least intrusive and proportional to the risk.
Protection:	The learning gained will be used to keep others safe.
Partnership:	Agencies will aim to understand how well they collaborated and apply what they learned to improve partnership performance and safeguarding.
Accountability:	Transparency and accountability are crucial for safeguarding procedures. For the review, explore and discuss the accountability of agency choices.

1.1.6 The review examined agency responses and support given to Robert, a resident of Swindon, before his death in January 2023.

[1] https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted
[2] https://www.scie.org.uk/safeguarding/adults/introduction/six-principles

1.1.7 In addition to agency engagement, the review looked at the last six months of Robert's life (August 2022– January 2023) to discover any relevant history, signs, or maltreatment before his death, if Robert received support in the community and any impediments to Robert's support. The panel and Michelle agreed upon this period, given that Robert began drinking at this point and sought support from services. Agencies that engaged with Robert before this date provided a summary.

1.1.8 The review aims to identify the themes and learn from the thematic review to find suitable solutions to reduce the risk of harm.

1.1.9 This review process does not replace the criminal or coroner's courts nor serves as a disciplinary procedure. It aims to determine how agencies may improve their practices by learning from this review to prevent future deaths in similar circumstances.

1.1.10 Robert was admitted to the hospital due to his alcohol dependency. He also had a history of overdosing and self-inflicted cuts that required medical attention but were not life threatening. Robert had pneumonia and self-reported to have Chronic Obstructive Pulmonary Disease (COPD).

1.1.11 Michelle found Robert's body at their home.

1.2 Case Summary

1.2.1 Robert acquired an alcohol addiction in August 2022 and was off sick with anxiety from work. Robert began consuming alcohol day and night in October 2022, which made him susceptible to falls.

1.2.2 Robert smoked twenty cigarettes a day.

1.2.3 Facial injuries resulting from a fall/s were recorded on the South Western Ambulance Service NHS Foundation Trust (SWAST) contacts dated 23/12/22 and 30/12/22. The ambulance was called to Robert's home twenty days before his death. He was noted to be intoxicated with many facial injuries resulting from a previous fall. He had an open wound on his face, an injury to his nose, a carpet burn, and a golf ball-sized lump on his forehead. Robert expressed a wish to die and was seen by a mental health service.

1.2.4 Eight days before Robert died, his employer reported Robert's self-neglect, alcohol abuse, and risk of suicide to Swindon Borough Council as a Safeguarding Adult Concern.

1.2.5 The police sudden death report highlighted the following historic injuries:

- His left eyebrow had a large scab and a cut, and the blood appeared to have been there for an extended time.
- A 2cm old scratch down his left cheek.
- Unidentified marks to the left eye and possibly bruising.

- A small lump above his right eye about the size of a gumball.
- A large carpet burn on his face.
- A golf-sized bruise on his abdomen, which was green in colour.
- Possible fracture or dislocation with a large bruise under the knee.

1.3 Equality and Diversity

1.3.1 The review Reviewer and panel considered the protected characteristics under the Quality Act 2010.

1.3.2 In this review, disability is the factor. Robert self-reported COPD and anxiety in August 2022 to the ambulance crew. According to information from the private ambulance service and the Great Western Hospital NHS Foundation Trust (GWH), Robert intentionally cut his wrists in October 2022.

1.3.3 Self-harm is not a mental disorder but is associated with mental distress[3].

1.3.4 COPD refers to a group of lung diseases that cause difficulty breathing. It is a frequent condition that primarily affects middle-aged or older smokers.[4] Robert was reportedly a regular smoker of fifteen to twenty cigarettes. There were no agencies with documentation confirming the diagnosis or had prescribed treatment for COPD.

1.3.5 Robert was diagnosed with hypertension and prescribed medication. However, he said he no longer took them because he wanted to die.

1.3.6 Robert self-referred to Talking therapies in April 2019; he reported experiencing depression and anxiety.

1.3.7 Depressive symptoms may manifest as a loss of interest in previously enjoyed activities, accompanied by persistent melancholy and sorrow. Additionally, individuals may experience bodily manifestations, including appetite loss, exhaustion, and various aches and pains.[5]

1.3.8 This could result in the absence of personal care and the home environment, leading to neglect of oneself and the living space.

1.3.9 At this time, Robert was not observed to be self-neglecting. However, beginning in August 2022, his partner Michelle observed decreased self-care; he no longer ate or addressed his hygiene. Michelle was responsible for keeping the household.

[3] https://www.rethink.org/advice-and-information/about-mental-illness/learn-more-about-symptoms/self-harm/
[4] https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/
[5] https://www.nhs.uk/mental-health/conditions/clinical-depression/overview/

1.3.10 The panel determined that Robert's excessive drinking from August 2022 onwards was a significant contributor to his self-neglect and exacerbated his anxiety and depression.

1.3.11 Alcohol and mental health are intricately intertwined. Overindulgence in alcohol can have detrimental effects on one's health since some individuals may drink to alleviate the symptoms of mental ill health.[6] [7]

1.4 Terms of Reference

1.4.1 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.

1.4.2 The terms of reference presented to Michelle were approved.

1.4.3 The critical question to be addressed by the review was:

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?

1.4.4 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)?

[6] https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/alcohol-and-mental-health
[7] https://www.drinkaware.co.uk/facts/health-effects-of-alcohol/mental-health/alcohol-and-depression

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?

1.5 Methodology

1.5.1 A hybrid methodology combining root cause analysis and practitioner events was employed for a comprehensive and targeted review.

1.5.2 The first meeting of the review panel took place on 23 October 2023, during which panel members presented details concerning their agency's encounter with Robert and agreed with the Terms of Reference.

1.5.3 The panel set the review term between August 2022 and January 2023. The panel agreed the period accurately reflects the challenges discovered during scoping and consultation with relevant agencies.

1.5.4 The panel met a total of four times.

1.5.5 Two practitioner meetings were held to discuss the work undertaken with Robert and the report's findings.

1.5.6 All panellists and practitioners were invited to share their thoughts on the recommendations they believed should be included in the final report. The panel discussed each of these recommendations.

1.6 Involvement of Family and Friends

1.6.1 The Reviewer and review panel recognised the critical role Robert's family may play in the review.

1.6.2 The Reviewer spoke with Robert's long time partner, Michelle. Michelle was emailed information regarding the Adult Safeguarding Review, and the Swindon Safeguarding Partnership provided her with contact information for support services.

1.6.3 Michelle had been with Robert since 1996, the final three weeks of his life; she had taken respite with her sister, returning every three days. She confirmed they were never separated.

1.6.4 Michelle was aware of Robert's three previous suicide attempts, for which he was hospitalised and then discharged home.

1.6.5 Michelle informed the Reviewer that she and Robert had been on holiday to Egypt in June 2022. In August 2022, Michelle found Robert in bed when she returned home during the day. He disclosed that he had been drinking and was signed off sick from work due to feeling anxious. He had worked in IT from home since the pandemic, which she believed was not his liking, as he had previously enjoyed going into the office. He began questioning his ability to work and felt he could not do it anymore.

1.6.6 Robert did not discuss his feelings with Michelle, and she recalled her friend who tried to talk to him about his drinking, but he told her, "If you have a broken arm, it can be fixed, (knocking on his head) but you can't fix this."

1.6.7 From October 2022, she stated Robert was drinking 24/7, not eating or looking after himself; she tried to get help for Robert by calling the Samaritans and alcohol lines and going to the GP.

1.6.8 Michelle went to the GP to speak with Robert's GP on 28 December 2022 and showed them photographs of Robert's bruises from falling over while intoxicated. Despite the GP not seeing him face-to-face, she was concerned that the GP would continue to sign him off sick with anxiety. They denied her request for a house call, citing Robert’s ability to attend the practice. Michelle feels he should have been seen.

1.6.9 Michelle recalls a visit from what she believes was the crisis team, which had prescribed him anti-depressants but warned him against taking them while drinking and told him they were not a long-term solution. Before mental health intervention, he was urged to stop his drinking, but no alcohol help was provided.

1.6.10 Michelle was informed of the review's progress and the report was sent to her for comment.

1.7 Contributors to the Review

1.7.1 The following agencies and their contributions to this 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

1.8 The Review Panel Members

1.8.1 The Panel members for this review were the following:

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

1.9 Reviewer and Author of the Overview Report

1.9.1 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.

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

1.10 Parallel Reviews

1.10.1 No other reviews in progress.

2.0 Background Information

2.1 The Facts

2.1.1 Robert was found deceased by his partner In January 2023.

2.1.2 Michelle last saw Robert four days before his death, and Michelle's daughter last saw him two days before his death.

2.1.3 Robert disclosed his intention to drink himself to death to Michelle. Michelle was compelled to leave the home as a result of Robert’s alcohol dependence.

2.2 Background Information about Robert

2.2.1 Robert died at the age of 53. He was in a relationship with Michelle for 27 years, and they had no children.

2.2.2 Michelle reported that Robert had previously worked in IT and excelled. However, during COVID-19 and the transition to working from home, Robert began questioning his ability to perform his duties. In August 2022, he began consuming excessive amounts of alcohol, and by October 2022, this had escalated.

2.2.3 Before August 2022, Robert had one contact with the mental health services offered by AWP and no previous contact with Turning Point.

3.0 Key Events

Date	Activity	Agency
04.08.2022	Robert presented to the hospital with hypokalaemia[8] and hyponatremia[9]. Robert, who resided with his partner, self-identified as a non-smoker but had consumed excessive amounts of alcohol throughout the previous year.	GWH
04.08.2022	Robert called the Practice to report that he is not eating much and has been producing bile; he is currently consuming a bottle of wine and indicated that this has been his way of life. When seen, he disclosed that he is experiencing anxiety and wishes to alter his drinking pattern.	GP
10.08.2022	Robert reported not eating and drinking excessively and believing this cannot be sustained. He was provided with AA-related information.	GP
18.08.2022	Robert received a telephone call to discuss his blood results. He advised that he had been consuming two bottles of wine daily for a few months, which was worsening. He has been signed off from work. Depressed and utilising alcohol as a coping strategy. Intrusive thoughts plague him, but he has no intention of acting upon them. He requested to commence antidepressants and was told it may take three to four weeks to take effect; he was urged to minimise his alcohol use and prescribed antidepressant medication. He was issued with a MED3 statement: Not fit for work.	GP
21.08.2022	111 call by Robert following self-harm and overdose. Paramedics were dispatched to Robert's home. Robert had overdosed on CBD oil[10] in an attempt to end his life. Robert disclosed consuming two bottles of wine and eleven cans of lager daily. His use of alcohol had escalated in recent weeks. He declared that he could not abstain from alcohol and consumed very little food. Robert mentioned experiencing poor mental health. According to the paramedic records, this began three weeks prior as a result of marital issues. His wife had departed the family home temporarily. Robert, after two days of taking Sertraline (antidepressants) given by his doctor, stopped taking these. He reported experiencing abdominal pain for two weeks. Ten days prior, he had been hospitalised for one night due to hypokalaemia. Robert was transported to the hospital.	SWAST
	Presented to the Emergency Department (ED) with a self-poisoning episode, with five prior attendances reported. Robert was referred to the AWP Mental Health Liaison Team (MHLT).	GWH
22.08.2022	Following GWH's referral to MHLT, AWP made initial contact with Robert. Upon determining that Robert's presentation was due to substance abuse rather than ill mental health, the MHLT assessed him and then discharged him. The MHLT practitioner spoke with the Substance Misuse Team.	AWP

[8] https://patient.info/doctor/hypokalaemia

[9] https://patient.info/treatment-medication/hyponatraemia-leaflet

[10] A chemical found in cannabis.

24.08.2022	GWH referred Robert to Turning Point; he had consented to the referral.	Turning Point
30.08.2022	He disclosed to the GP that he had just been hospitalised and that he had used cannabis oil to aid with sleep. However, it worsened his mood. He reported having resumed employment and had begun taking antidepressants. During hospitalisation, Robert disclosed withdrawal symptoms and was prescribed detoxification medication. Following the hospitalisation, which served as a wake-up call, he ceased using alcoholic beverages.	GP
08.09.2022	Robert reportedly was suicidal and intoxicated when 111 was called. Robert's partner had left for work at 0700 hours and, upon her return home, discovered him lying on the floor near the loft with an open loft hatch and a rope with a noose attached to the end of the floor by the stepladder. Robert informed the paramedics that he had consumed two bottles of wine; three empty bottles were found. The paramedics could not confirm how many bottles of alcohol Robert had drunk. His partner stated that Robert had deteriorated significantly over the last month since she took a break from the relationship in June. Robert had asked for a pill to finish him off. Robert was referred to the MHLT.	SWAST
	Robert was discovered intoxicated on the floor and was transported to the emergency department via ambulance. He presented with alcoholism, mental illness, and suicidal ideation. Robert was discovered by his partner in the garage with a noose he had hung up; he had not attempted to use the noose and was described as feeling remorseful and upset. He disclosed work-related pressures and alcohol withdrawal.	GWH
	MHLT assessed Robert in the ED. His partner discovered him intoxicated at home and escorted him to his bedroom upstairs. She found a rope. Robert had, however, indicated that he had not attempted suicide by hanging. Robert's partner informed MHLT that she did not want him to spend the night at home. MHLT reported that Robert was referred to Talking Therapies and Turning Point; a referral to the GP was made to facilitate access to physical and mental health care.	AWP
09.09.2022	The discharge summary provided to the GP detailed a suicide attempt and chronic alcohol consumption. Robert did not attend the planned appointment with his GP.	GP
10.09.2022	Robert attended the ED in a mental health crisis, namely extreme anxiety, which he had been managing with alcohol for the previous four weeks. He disclosed having recent suicidal ideation and an attempted suicide. Robert was referred to the MHLT and the Swindon Intensive Services (SIS)[11] for further assessment.	GWH
	Robert, who was seen in the ED, disclosed that his suicide ideation had worsened. He admitted to rigging a rope in the loft and putting his head through it while drinking wine; his partner discovered him on the floor. Robert was hospitalised for the night.	AWP

[11] A rapid assessment and treatment for people who are experiencing a mental health emergency

	According to Robert's GP records, he was seen in the substance misuse clinic. The GP received a letter from the GWH Substance Misuse Team stating Robert had reported experiencing a depressed mood and racing thoughts and was using alcohol as a coping mechanism. Robert disclosed that he had consumed two bottles of wine, tied a noose in his loft, and passed out. The letter suggested that Robert be referred to SIS, and the substance abuse team requested that Turning Point contact Robert.	GP
11.09.2022	Robert was referred to SIS for home treatment.	AWP
12.09.2022	SIS was unable to complete an assessment as a result of Robert's intoxication. He disclosed that he felt hopeless and drank alcohol as a treatment for his anxieties. SIS communicated with Robert's partner.	AWP
13.09.2022	SIS conducted an assessment in the presence of Robert's partner. They observed that Robert, who had always suffered from anxiety, was feeling guilty and thinking about his faults in life. While without explicitly disclosing his alcohol consumption, he did express his intention to improve. He admitted that he was aware that addressing this would grant him access to more support resources, including counselling. It was determined that he did not need SIS services, and he was discharged to his GP.	AWP
16.09.2022	GP communicated with Robert. The GP records indicate that he is receiving counselling and is under the care of the mental health team. His suicide attempt was regretted, and he is currently reducing his alcohol consumption. The MED3 statement read: Unfit for work.	GP
22.09.2022	Robert was booked for an assessment with Turning Point.	Turning Point
26.09.2022	Robert's partner contacted SIS to inform them that Robert was not engaging with Turning Point. She reported that she would contact his GP for support.	AWP
30.09.2022	A domestic altercation involving Robert and his partner, Michelle. Following a verbal altercation between the pair, Michelle informed the police that Robert had been pushed and fell to the ground. Michelle mentioned Robert's intoxication, which was putting a strain on their relationship. Michelle explained that she pushed Robert in frustration over the impact of his drinking on his mental health. Michelle was taken to her daughter's home for the night. Robert did not wish to pursue a complaint. The police completed the Domestic Abuse, Stalking and 'Honour' based violence (DASH)[12] risk assessment and the Public Protection Notice (PPN), indicating a standard risk not required to be disclosed to other agencies.	Police
	Robert did not attend his planned appointment at the GP practice.	GP
03.10.2022	The case was discussed at the Daily Domestic Abuse Conference with Robert as the victim.	Turning Point and Police
06.10.2022 – 22.10.2022 Admission	Robert was transported by ambulance to the ED. Michelle's daughter called 999 after discovering Robert with a cut to the left wrist. The paramedics observed empty alcohol bottles and a bottle containing smelly dark urine.	GWH

[12] https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf

	Robert was admitted for treatment of pneumonia, and an alcohol detoxification regimen was initiated. Robert disclosed having suicidal thoughts and a desire to end his life. Initially agitated upon being seen, he regained his composure within ten minutes. Following the departure of his partner one week previously, he has been abstinent from food and has consumed just alcohol, expressing a desire to die. Although he denied having overdosed, he had neglected to take his HTN medication (hypertension) for an extended period as he no longer cared and continued to report suicidal thoughts. Robert was referred to the MHLT.	
	GP records indicate an admission for sepsis.	GP
11.10.2022	Robert cancelled his scheduled appointment due to his hospitalisation at GWH for pneumonia and the medical detoxification process for alcohol. He agreed to communicate upon his discharge.	Turning Point
19.10.2022	Seen in the rheumatology clinic.	GP
24.10.2022	Robert informed the GP that he had been discharged over the weekend. For his anxiety, he wanted anti-depressants and was turning to alcohol as a coping mechanism. He was reportedly engaged with Turning Point and had abstained from alcohol for the past two weeks. He disclosed that both his partner and her daughter are supportive. He described reliving significant life events.	GP
26.10.2022	Robert was redirected to the Primary Care Liaison Service (PCLS) after calling 111. He disclosed that he was anxious and wished to speak with someone. He said he had an appointment with the mental health nurse at his GP Practice on 07.11.2022.	AWP
02.11.2022	After ten days passed with no response from Robert, a letter was sent to him. As stated in the correspondence, his case would be closed without further communication.	Turning Point
03.11.2022	The GP spoke to Robert to see whether he needed vitamins. He stated he had entirely abstained from alcohol and was consuming two meals per day. His mood remained low, and he lacked motivation.	GP
15.11.2022	Robert was closed to Turning Point.	Turning Point
17.12.2022	Robert declared that it had been three weeks since his last alcoholic drink and that he had been attending AA meetings for the past two weeks. He reported a low mood and was fixated on prior mistakes. He spoke of being stressed at work and having a supportive partner. He consented to engage in Talking Therapies and increase his antidepressant dosage if there is no improvement in his mood. A text was sent to Robert with the contact details for the Talking Therapies. The GP records state Robert was at risk of deliberate self-harm.	GP
15.12.2022	Robert did not attend his dermatologist appointment and was discharged as a result. His GP was informed.	GWH
12.12.2022	Mental Health Review by phone. Robert disclosed that he was taking the antidepressant and observed an improvement in his mood, motivation, and sense of optimism. He stated he did not consume alcohol and had ceased attending AA meetings, believing he could manage everything alone.	GP

23.12.2022	A call to 999 was received; Robert had suffered a fall-related injury to his nose and ear. According to the reports, he was dependent on alcohol and fell three to four times daily. It was assumed that his alcohol usage was the cause of his falls. Robert declined to go to the hospital and was determined to have the capacity to make the decision. Robert was counselled with advice on head injuries and declined safeguarding and signposting. His partner stated she had a strong support system and was unafraid of Robert.	SWAST
28.12.2022	Robert requested a sick note and disclosed that his anxiety and depression had flared up when he returned to work and that he required additional time.	GP
29.12.2022	Michelle presented Robert's GP Practice with a photograph of Robert, who was afflicted with multiple injuries and requested a home visit from the GP. According to the GP report, Robert's partner indicated that he was not maintaining his hygiene and consuming alcohol. Robert was not eating or drinking; Michelle recollects being instructed to tell Robert to attend the practice.	GP
30.12.2022	A 999 call after Robert suffered a fall-related head injury and subsequent overdose. It was noted that alcohol use led to frequent falls, and numerous facial injuries were recorded. According to Robert's partner, Robert was in denial and refused to get help for his alcoholism. Robert was transported to the hospital.	SWAST
	Robert attended the ED; his partner reported Robert had taken 10 x Ramipril tablets 36 hours ago and was asymptomatic. He missed some of his doses and thought he needed to compensate. He denied any suicidal intent. Robert disclosed that he had experienced three instances of collapse and had many open wounds to his face within the past three days. It appeared that a number of the lacerations were healing. He denied being intoxicated before these falls.	GWH
31.12.2022	Michelle contacted the police, stating that she was having difficulty managing Robert, whom she reported to be an alcoholic and that she wanted him to be removed from the home. Robert had been consuming excessive amounts of alcohol since August 2022, and Michelle reported she was emotionally and mentally spent from providing the continual care he required while intoxicated. Michelle informed the police Robert had self-harmed previously and had attempted to take his own life. The police and ambulance were called as a result. Michelle wanted Robert evicted. However, they jointly owned the property. Police informed her it was a civil matter. A referral to the National Centre for Domestic Violence (NCDV) and a PPN was made.	Police
05.01.2023	A 999 call was made, and Robert was reported to be intoxicated and "not making sense". He expressed to his partner his wish to die. It was documented that Robert had attempted suicide in the past and that he had neglected to take his prescribed medication for two weeks. Robert disclosed his intention to kill himself to the paramedics and requested a knife. His partner had concealed all the knives. According to the patient records, Robert was referred to the crisis team in September 2022, where he was advised to minimise his alcohol consumption. However, he did not attend the scheduled	SWAST

	appointments, including the one with his GP. Robert was transported to the hospital.	
	Robert was transported by ambulance to the ED. Over the past two months, Robert had been experiencing suicidal ideation and had concurrently escalated his alcohol usage. His partner was observed to be struggling, and Robert was not taking any medication. Robert was referred to AWP MHLT.	GWH
06.01.2023	Robert preferred to return home without seeing the MHLT or Substance Misuse Liaison (SML). He stated that he shared ownership of the property and, therefore, could return home. His partner, however, was averse to his returning home out of concern for his intoxicated behaviour. His refusal to MHLT persisted, but he consented to a vitamin regimen and an alcohol assessment.	GWH
	Robert was referred to MHLT by GWH; he had had a fall while intoxicated. Robert did not want to be seen by the MHLT; the ED consultant agreed that Robert could make this decision and was discharged from the MHLT caseload.	AWP
	Police were dispatched in response to an allegation that Robert had attempted to enter the home through a window after Michelle had refused to let him in. Robert was discharged from GWH that morning. Michelle refused to allow him back at the address until he found assistance for his alcoholism since she was no longer able to manage him. Police were told he had refused to engage with multiple agencies. Michelle had been unsuccessful in attempting to obtain support. Robert was arrested to avert a breach of peace precipitated by his insistence on remaining at the property. He received an assessment by the Liaison and Diversion Service (LADS) while in custody. He was given an appointment the following day to be seen by mental health. Michelle had moved in with her sister.	Police
	SIS was notified by the police that Robert had entered his home by climbing through the window after his partner refused to let him in. LADS saw him in the police station, and SIS had planned to meet with him the following day.	AWP
07.01.2023	SIS called Robert to be reminded of his next appointment. He refused to be seen by SIS and would not attend his scheduled appointment. He explained that he was staying at a hostel as his partner did not want him to return home.	AWP
09.01.2023	A high-intensity user letter was written to the GP; Robert had attended the ED six times in the last 12 months - the occurrences were noted to the GP.	GWH
10.01.2023	Robert was referred to the service by AWP because his alcohol dependence had worsened over the previous eighteen months, and he had increased suicidal thoughts while intoxicated. The referral mentioned that he was experiencing mild physical withdrawal symptoms and consumed several beers daily.	Turning Point
18.01.2023	AWP was notified by Swindon Borough Council of a safeguarding referral that Robert's employer had initiated. A welfare visit to his home revealed that his employer was concerned by the condition of his appearance and drinking.	AWP
	The Safeguarding Hub requested additional information from the ICB GP and AWP, including his care and support needs, mental health, and	ASC

	the support he was receiving. This objective was to ascertain the necessity of Section 42: Care Act 2014 enquiry[13].	
Two days before Robert Died	Robert cancelled his assessment with Turning Point as he felt unwell.	Turning Point

4.0 Themes and Analysis

Theme One: Making Safeguarding Personal and Professional Curiosity

4.1.1 Making Safeguarding Personal (MSP) is a sector-led strategy that seeks to promote a focus on outcomes for safeguarding work and various approaches to assist individuals in improving or resolving their circumstances.[14]

4.1.2 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.

4.1.3 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.

Care Act 2014: Section 11: Refusal of assessment

(1)Where an adult refuses a needs assessment, the local authority concerned is not required to carry out the assessment (and section 9(1) does not apply in the adult's case).

(2)But the local authority may not rely on subsection (1) (and so must carry out a needs assessment) if—

(a)the adult lacks the capacity to refuse the assessment, and the authority is satisfied that carrying out the assessment would be in the adult's best interests or

(b)the adult is experiencing, or is at risk of, abuse or neglect.

(3) Where having refused a needs assessment, an adult requests the assessment, section 9(1) applies in the adult's case (and subsection (1) above does not).

(4) Where an adult has refused a needs assessment and the local authority concerned thinks that the adult's needs or circumstances have changed, section 9(1) applies in the adult's case (but subject to further refusal as mentioned in subsection (1) above).

4.1.4 The Blue Light Approach is a project to offer alternative care pathways and techniques for dependent drinkers with complex needs who are not engaged with treatment providers.[15]

[13] https://www.legislation.gov.uk/ukpga/2014/23/section/42

[14] https://www.local.gov.uk/our-support/sector-support-offer/care-and-health-improvement/making-safeguarding-personal#:~:text=Making%20Safeguarding%20Personal%20(MSP)%20is,improve%20or%20resolve%20their%20circumstances.

[15] https://alcoholchange.org.uk/help-and-support/training/for-practitioners/blue-light-training/the-blue-light-project

4.1.5 The project resulted in a manual detailing essential principles and various tools for working with individuals without contact with services.

Principles
1. Take every opportunity
2. Not everyone will change
3. Change is not the only option
4. Whole system approach
5. Holistic Approach
6. Recording unmet need
7. Learning lessons

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

4.1.7 Supporting involvement should also be guided by the six principles of safeguarding adults, emphasised in the Local Government and Association of Adult Social Services Making Safeguarding Personal project[16], in addition to the Care Act 2014: Section 11 and the manual.

4.1.8 The employment of legal frameworks to encourage engagement is also highlighted.

Theme Two: Alcohol and Safeguarding

4.1.9 The Care Act applies to individuals who are experiencing alcohol issues, and in particular, self-neglect.[17]

4.1.10 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.

4.1.11 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.

4.1.12 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.

4.1.13 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. Neglecting to exercise legal frameworks and honouring an individual's autonomy could result in the individual dying or being vulnerable to exploitation and abuse in violation of Article 2 (Right to life) or Article 3 (Freedom from.. inhumane or degrading treatment).[18]

[16] https://www.adass.org.uk/adassmedia/stories/making%20safeguarding%20personal.pdf
[17] https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/Safeguarding-guide-final-August-2021.pdf
[18] https://www.legislation.gov.uk/ukpga/1998/42/schedule/1

4.1.14 Alcohol Change UK published a Report, 'An analysis of alcohol-related Safeguarding Adult Reviews.'[19] Alcohol was identified as a contributing element in several tragic incidents, according to the analysis. Adults with chronic alcohol issues were found to fall within the remit of adult safeguarding. The report made ten recommendations.

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

Theme Three: Legal Literacy

4.1.16 Three primary legislative measures can be employed to safeguard and support individuals who are dependent on alcohol.

1. The Care Act 2014
2. The Mental Capacity Act 2005
3. The Mental Health Act 1983 (amended 2007)

4.1.17 The Care Act 2014 nine principles should be followed[20]:

Empowerment

- Approaches to this client group should be built on the recognition that there are things that we can do to help these people.
- The response to chronic dependent drinkers should be non-discriminatory. They have as much right to protection from harm as anyone else. Services should not be denied or adjusted because of disapproval of their lifestyle or the workload they may require.

Proportionality

- Coercive legal frameworks with this client group should be a last resort and used rarely after all other approaches have been exhausted.

Protection

- Managers and management systems must support staff to take a positive and assertive approach to this client group.

Partnership

- Use a multi-agency approach.
- Wherever possible, actions and decisions should involve the person being supported.

Accountability

- A governance framework is required to manage this area of need; an identified local body such as the Safeguarding Adults Board or Health and Wellbeing Board should ensure this group is well managed.

Prevention

- Use SARs and other serious case reviews to learn and improve how this group is supported continually.
- If existing resources cannot meet people's needs, these unmet needs should be identified, recorded, and reported to commissioners.

[19] https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/ACUK_SafeguardingAdultReviews_A4Report_July2019_36pp_WEB-July-2019.pdf?mtime=20190722092539

[20] https://proceduresonline.com/trixcms2/media/14068/safeuarding-vulnerable-dependent-drinkers.pdf

4.1.18 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.[21]

4.1.19 Legal literacy, particularly the Mental Capacity Act, was a recurring issue in Swindon's four SARs.

4.1.20 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.

4.1.21 Tower Hamlets v. PB (2020) concerned a 52-year-old man with a history of alcohol abuse and the question of whether or not he had the capacity to make decisions regarding his care and residence.[22]

There were several key points arising from the case.[23]

• If an individual has the capacity to make decisions around care and residence and is content to remain in the placement while being able to access alcohol, local authorities may feel that they have no other option than to let that individual take risks with their health that the local authority is uncomfortable with.

• The real question is how alcohol consumption affects individuals' decision-making capacity in other areas. Capacity assessments should consider the individual's ability to understand, use, retain and weigh information about the consequences of their alcohol consumption and how that affects their decision-making in other vital areas, including care and support. The effect on their health and potential risk to their life will be part of that consideration.

• If an individual cannot understand, use, retain and weigh information because of their dependency on alcohol, they will lack the capacity to make those decisions. However, where the individual clearly understands the risks to their health presented by their use of alcohol, it is likely to be found by courts that they will have the capacity to make decisions about care and support. This will apply whether an individual does not have a realistic view about how they will moderate or manage their drinking. As long as the individual understands the risks posed by heavy drinking, although the decision may be considered unwise, it does not mean they cannot necessarily make it.

4.1.22 The case highlighted the need to balance capacity with unwise decisions.

4.1.23 The Mental Health Act defines a mental disorder. Detaining an individual under the Act owing to their impaired cognitive ability caused by continuous alcohol use is an uncommon occurrence.

4.1.24 Although it is illegal to detain or attempt mandatory treatment based on alcohol dependence alone, the language of the Act suggests that it is feasible to detain an individual who is profoundly mentally ill due to the consequences of alcohol, including cognitive impairment, severe depression, and acute confusion.[24]

[21] https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

[22] https://www.39essex.com/vice-presidents-judgment-on-capacity-and-alcohol-dependence/

[23] https://invicta.law/news/capacity-to-make-decisions-on-care-and-alcohol-dependency/

[24] https://proceduresonline.com/trixcms2/media/14068/safeguarding-vulnerable-dependent-drinkers.pdf

Theme Four: Alcohol Dependence and Mental Health

4.1.25 The Mental Health Foundation[25] reports the following:

- As a depressant, alcohol can alter the equilibrium of chemical messengers in the brain, influencing behaviour, emotions, and ideas.
- Alcohol can impair the processing of information by the brain and make it more difficult to discern one's genuine emotions and the potential repercussions of one's actions.

4.1.26 According to Alcohol Change UK[26], one in every four individuals in the United Kingdom will suffer from a mental health issue annually, and alcohol is the coping strategy of choice for those who wish to manage stress, anxiety, depression, or other mental health conditions.

4.1.27 Professor Dame Carol Black's Independent Review[27] identified mental health issues and trauma as the underlying causes of alcohol and drug abuse. Nevertheless, individuals are frequently denied access to mental health care until their substance dependence is resolved and may also be denied drug abuse services until their mental health is addressed. As a result, she advocated for the collaboration of services to resolve the issue.

4.1.28 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.

4.1.29 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.

4.1.30 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.

4.1.31 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.

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

4.1.33 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.

[25] https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/alcohol-and-mental-health
[26] https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-and-mental-health
[27] https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

Theme Five: Self Neglect

4.1.34 Self-neglect was the most common reason for Safeguarding Adult Reviews conducted between April 2017 and March 2019, accounting for 45% of all reviews.[28]

The findings of the review revealed[29]:

- Too accepting of lifestyle choices and insufficient professional curiosity.
- Failure to escalate to senior managers.
- Mental capacity and risk assessments are insufficiently robust.
- No agreed strategies to continue to engage.
- Delays in raising safeguarding concerns or commencing Section 42 enquiries.
- Poor record keeping of decision making.

4.1.35 These findings echo the past SARs and those from Swindon on insufficient professional curiosity and legal literacy.

4.1.36 The University of Bristol discovered that clinicians occasionally utilised capability to justify not intervening in cases of suspected self-neglect, thereby placing individuals at grave risk. "Social care practitioners burdened with an overwhelming workload may inadvertently or deliberately "dispose" of cases utilising capacity as a means to do so. Supporting protection and promoting autonomy should not be mutually exclusive; rather, they should be harmonised to assist those neglecting themselves effectively."[30]

4.1.37 Utilising evidence from self-neglect work, a learning resource created by Suzy Braye and Michael Preston-Shoot illustrates how Making Safeguarding Personal can improve the health, safety, and well-being of those who engage in self-neglect.[31]

4.1.38 In addition to the resource, they published an article, 'Towards a Model of Understanding Facilitators and Barriers to Best Practice.[32]

4.1.39 The following has been extracted from the article:

Making Safeguarding Personal

To speak with the adult and gain insight into their private lives, aspirations, anxieties, and setbacks.

Autonomy

Balancing autonomy and duty of care.

Assessment

[28] https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

[29] [29] https://dudleysafeguarding.org.uk/wp-content/uploads/2022/11/Learning-from-self-neglect-SARs.pdf

[30] https://www.bristol.ac.uk/policybristol/policy-briefings/adult-safeguarding-practices/

[31] https://www.local.gov.uk/our-support/partners-care-and-health/care-and-health-improvement/safeguarding-resources/self-neglect-worbook

[32] https://uobrep.openrepository.com/bitstream/handle/10547/623309/Paper%2bSix%2bv3%2bfinal%2bpublication%2bversion.docx.pdf?sequence=2&isAllowed=y

A history of "unwise decisions" does not preclude the presumption of mental capacity; instead, it should be assessed. Instead of viewing each referral or hospital admission in isolation, needs and risks should be reviewed in light of the patient's medical history.

Planning

Care plans should meet professional standards in detail, contingency planning and updates when needs change or risks increase.

Family and Social Context

An exploration of a "think family" methodology that centres on the intricacies of relationship dynamics is required.

Legal Literacy

All legal options should be considered as part of assessment and care planning.

Silo Working

When agencies know one another's actions, they should deliberate on the ramifications of case closure and coordinate.

Whole System Meetings

Multi-agency working and strategy meetings are to be planned.

Recording

A thorough documentation system facilitates communication across practitioners and agencies while fostering comprehension of individuals, their families, and other social networks.

4.1.40 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.

Theme Six: Multi-Agency Working

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

4.1.42 Multi-agency working allows practitioners to evaluate an individual's issues from multiple perspectives rather than focusing on one area.

Theme Seven: Think Family

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

4.1.44 Research findings consistently demonstrate that female family carers endure a greater degree of substantial psychological suffering, shame, and carer load.[33]

4.1.45 Any adult over 18 who provides care for a disabled, older adult or ill adult is entitled to a carer's assessment under Section 10 of the Care Act 2014. The carers' mental and physical health, capacity, willingness to provide care, and interpersonal relationships should be discussed during these assessments[34].

4.1.46 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.

5.0 Conclusions

5.1.2 This review intends to understand the circumstances behind Robert's death in January 2023 and to learn from prior SARs to improve the response to safeguarding by the Swindon safeguarding partnership agencies.

5.1.3 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.

5.1.4 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.

5.1.5 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.

[33] https://pubmed.ncbi.nlm.nih.gov/27014594/

[34] https://www.legislation.gov.uk/ukpga/2014/23/section/10/notes#:~:text=Section%2010%20%E2%80%93%20Assessment%20of%20a%20carer's%20needs%20for%20support&text=This%20section%20creates%20a%20single,time%2C%20or%20in%20the%20future.

6.0 Recommendations to the Partnership

Individual Agency Lessons Learnt/Key Findings

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

6.1.1 Practitioners should raise awareness of and use more professional curiosity about risks and safeguarding matters when conducting risk assessments.

6.1.2 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.

6.1.3 Increased use of multi-agency professionals' meetings in cases complicated by difficult engagement, lack of consent, multiple interrelated comorbidities requiring multi-agency input, etc.

6.1.4 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.

6.1.5 To consider including an individual's employer as a partner agency in terms of triangulating support and risk management

6.1.6 Access Services, AWP, and CGL have organised meetings to discuss complex cases. (Please confirm when the meeting began and the frequency of the meeting).

GP Practice

6.1.7 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.

Great Western Hospitals NHS Foundation Trust (GWH)

6.1.8 Within an emergency department, an assessment of capacity is often worded as "I believe looking at the balance of probabilities that this person has/lacks the capacity to 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.

6.1.9 A Trauma-informed approach to emergency department practice could be beneficial for patients presenting with mental health distress.

6.1.10 Referrals to other agencies (such as alcohol liaisons) should be recorded on each relevant occasion.

6.1.11 The Trust needs to strengthen the self-neglect resources available on the Intranet.

Multi-Agency Recommendations

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

6.1.13 Recommendation One: Making Safeguarding Personal and Professional Curiosity

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 address 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.

6.1.14 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.

6.1.15 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.

6.1.16 Recommendation Four: Alcohol Dependence and Mental Health

CGL currently 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.

6.1.17 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.

6.1.18 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.

6.1.19 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.

Acronyms

Adult Social Care	ASC
Avon and Wiltshire Partnership MHS Trust	AWP
Bath and North East Somerset, Swindon, and Wiltshire	BSW
Children Families & Child Health	CF&CH
Chronic Pulmonary Disease	COPD
Domestic Abuse, Stalking and 'Honour' based violence	DASH
Emergency Department	ED
Great Western Hospital NHS Foundation Trust	GWH
Integrated Care Board	ICB
Liaison and Diversion Service	LADS
Mental Health Liaison Team	MHLT
National Centre for Domestic Violence	NCDV
Primary Care Liaison Service	PCLS
Public Protection Notice	PPN
Safeguarding Adult Board	SAB
Safeguarding Adult Review	SAR
South Western Ambulance Service NHS Foundation Trust	SWAST
Substance Misuse Liaison	SML
Swindon Borough Council	SBC
Swindon Intensive Services	SIS
Swindon Supra Outreach Service	SSOS