SAR Brian

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SAFEGUARDING ADULT REVIEW

Swindon Safeguarding Partnership

1. INTRODUCTION

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

2. SAFEGUARDING ADULT REVIEWS

2.1. Section 44 of the Care Act 2014 places a statutory requirement on the Swindon Safeguarding Partnership to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Swindon Adult Safeguarding Partnership the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

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

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

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

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –
a) identifying the lessons to be learnt from the adult's case, and
b) applying those lessons to future cases.

2.2. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

2.3. All Swindon Safeguarding Partnership members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.4. This case was referred to the Practice Review (PRG) Sub-group of the Swindon Safeguarding Partnership on 27.5.21 and considered for a Safeguarding Adult Review at the meeting on 19.4.21.

2.5. The PRG Sub-group recommended that this case met the criteria for a SAR at a scoping meeting held on 29.6.21, and the Executive Group of the Board ratified this on 3.8.21.

2.6. The Safeguarding Adults Review was led by Patrick Hopkinson who is an Independent Consultant in Adult Safeguarding and who had no previous involvement with this case and no connection to the Swindon Safeguarding Partnership, or its partner agencies.

2.7. It should also be noted that Brian's death was considered under NHS England's Serious Incident Framework https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf and an Initial Incident Review (characteristically termed the 72-hour review) was conducted. Some information from this review was made available to the SAR author.

2.8. **The review**

This safeguarding adults review commenced on 29.9.21

2.9 Key areas to be addressed by the review were:

- How clinicians manage Mental Capacity Act assessments when services are declined
- Mental Health Assessments when Brian was/was not under the influence of substances and how this substance use impacted on his risk taking behaviours
- How Brian's autism and mental health concerns were managed in tandem. Was there a gap in services for mental health service users who have autism?
- The lack of decision making when a number of agencies are involved and over reliance on one particular service to manage risks,
- How was the safeguarding referral decision making made.
- How substance use, complex mental health and autism contribute to risk taking behaviours and how these contribute to self-neglect.
- Communication and information sharing across local authority boundaries.

2.10 **Contact with family and friends**

2.11 Brian's cousin was contacted to take part in the review.

3. BRIEF SUMMARY OF CHRONOLOGY AND CONCERNS

3.1. The chronology for this safeguarding adults review covered the period from 1st July 2020 to 7th February 2021.

3.2. The following services were involved with Brian during the time covered by the chronology:

- Turning Point
- Avon and Wiltshire Mental Health Partnership Trust (AWP)
- Autism Spectrum Disorder Team (ASD) – part of AWP
- Recovery Mental Health Team - part of AWP
- Swindon Intensive Service (SIS) – part of AWP
- Primary Care Liaison Service / GP
- Probation Service
- Housing Department - Swindon Borough Council
- Adult Social Care – Swindon Borough Council (ASC)
- Adult Safeguarding Team – Swindon Borough Council
- Great Western Hospitals NHS Foundation Trust (GWH)
- South Western Ambulance Service NHS Foundation Trust (AWASFT)
- Wiltshire Police
- Dorset and Wiltshire Fire and Rescue Service (DWFRS)

3.3. **Brian**

3.4. Brian was a white British man who was 43 years old when he died in a fire.

3.5. Brian lived with his mother but moved out of the family home when she died in 2019. Brian had two children who, at the time of his death, did not live with him. Brian had a sister who was in contact with his GP on his behalf. Brian also mentioned a brother, a cousin and another cousin who died on 23rd October 2020.

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

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

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

3.9. **Chronology from 1st July 2020 to February 2021**

3.10. In July 2020 Brian was discharged from the ASD team as they had finished their intervention which was to make assessments. The team provided several recommendations for Brian, including engaging with LIFT Psychology (Swindon LIFT offers one-to-one therapy and online or in-person courses in accordance with the National Institute for Health and Care Excellence (NICE) guidelines for common mental health problems) and being referred to the local authority for a Care Act assessment. Brian did not wish to engage with these interventions. The team also completed a Hospital Passport for Brian, which was intended to aid his interactions with healthcare staff by alerting them to his ASD related needs.

3.11. On 22nd September 2020, Brian was referred to the Primary Care Liaison Service by his GP who cited paranoid ideas with a background of drug taking, stating that Brian was only consuming cannabis and alcohol at the time. Brian was found at a train station later that day with thoughts to end his life. Brian was assessed and detained under section 2 of the Mental Health Act at Green Lane Hospital run by AWP where he would remain until 2nd October 2020.

3.12. On 30th September 2020, Brian was discussed at the Trust-wide daily risk management meeting following an incident on the ward where he was reported to have poured hot water over another patient the previous day.

3.13. Brian was assessed by an Approved Mental Health Professional and the AWP Safeguarding Team made a safeguarding referral to the local authority on behalf of the victim of this assault. AWP can find no communication from Swindon Borough Council's Adult Safeguarding Team regarding this referral. Ward staff were also advised to report the incident to the police on 101.

3.14. On 2nd October 2020, due to his aggression, Brian was transferred to a Cygnet Hospital psychiatric intensive care unit (PICU). AWP's records do not show under which section(s) of the Mental Health Act Brian was detained whilst in the PICU. The Consultant on the PICU did not think Brian was experiencing psychosis, suggesting instead that his presentation was more consistent with a formulation of personality disorder of the antisocial type, with EUPD traits (Emotionally Unstable Personality Disorder). The Consultant felt that Brian was self-reporting signs of psychosis to in order to have his needs met, including avoiding social issues such as debt. While on the ward, Brian was said to have disclosed that he had not been suicidal at the train station, only saying this to be detained; it was also reported that he had been asking how he could be detained on Section 3 of the Mental Health Act.

3.15. On 16th October 2020 Brian was discharged from the PICU with support from the Swindon Intensive Service (SIS), a team within AWP which offers rapid assessment and treatment for people who are experiencing a mental health emergency. The aim of the service is to offer treatment and care in an individual's own home as an alternative to hospital admission.

3.16. On 17th October 2020 Brian attended the Emergency Department in an agitated, paranoid state. Having slept in the hospital overnight Brian appeared stable and lucid when assessed under the Mental Health Act.

3.17. On 24th October 2020 Brian was found unresponsive outside his mother's house. He was treated for methadone overdose and hypothermia.

3.18. In November 2020 Brian was allocated a care coordinator from the Recovery Team, part of AWP. Over the next few months the care coordinator was involved in monitoring medication use, speaking with Brian's family and engaging with other professionals, in discussions around drug testing, housing, support and discussions around attendance at meetings including probation. Brian continued to engage with IMPACT Swindon & Wiltshire Active Recovery Service which is a free drug and alcohol service run by Turning Point, for his Methadone prescription and collected his own medication from a pharmacy**.** He was also under probation services. At this time, Brian said he was not using drugs. Brian was described by AWP as presenting with no risk to himself or others and Brian denied any paranoid thoughts.

3.19. On 30th November 2020, Great Western Hospital notified Brian's GP that Brian was a high intensity user of the Emergency Department, highlighting that high-intensity users are known to be more at risk and that their pattern of attendance may signify unmet care needs. This letter was received but there is no evidence on the GP records of any response to this.

3.20. On 26th December 2020, Brian twice attended the Emergency Department of the Great Western Hospital with a deterioration in his mental health. On the second occasion he had contacted the police since he was paranoid about his neighbour and was experiencing chest pain. Brian said that he was struggling with bereavement following the death of his mother two years previously. Brian was struggling with Christmas and felt that after Christmas his mental health would improve. He was found to be medically fit with no risks identified to himself or others and was discharged home to his flat.

3.21. Brian attended the Emergency Department of the Great Western Hospital nine times between 26th December 2021 and 26th January 2022.

3.22. On 28th December 2020 the Police were contacted by a hotel concerned about Brian's erratic and unpredictable behaviour whilst staying there. The Police attended and found Brian's mental health was deteriorating but that Brian was not at risk to himself or others.

3.23. On 8th January 2021 Brian was admitted to the Emergency Department observation ward following a psychotic episode. He threw himself to the floor sustaining an injury to his right hip. Brian had surgery on 11th January and was discharged on the 13th. Brian then telephoned the ambulance service stating he had been shot in the leg. A police officer attended and felt that Brian did not have the capacity to be at home and that Brian did not think he could cope at home by himself.

3.24. On 16th January 2021, Police attended due to Brian banging on neighbours' doors. Brian was detained under s136 of the Mental Health Act. The following day when Brian was assessed under the Mental Health Act, there was no sign of psychosis but of "drug induced behavioural issues" and personality disorder.

3.25. On 18th January 2021, SIS were informed that Brian had been aggressive towards a visiting family member. SIS visited with the family member present and Brian did not engage with the conversation aside from asking SIS to leave. Brian was reported by SIS to be unkempt and his flat untidy.

3.26. On 19th January 2021, Brian went to the Turning Point hub where he appeared "sluggish" and confused. Staff were concerned for his mental health and called an ambulance, which took two and half hours to arrive. In the intervening time the clinical lead at the hub provided support to Brian and to staff working with him.

3.27. On 21st January 2021, a safeguarding concern was raised by Turning Point with Swindon Borough Council's (SBC) safeguarding team since Brian's mental health was deteriorating. This was closed after screening on the basis that a care coordinator from AWP was in place and Brian was staying in Chippenham at the time of referral.

3.28. The safeguarding concern was shared with the care coordinator who responded to say that Brian's case would be escalated within AWP.

3.29. On 25th January 2021, SBC's safeguarding team notified Turning Point that their referral has been closed.

3.30. On 25th January 2021, the police were called by a neighbour due to Brian's "antisocial" behaviour. In the evening the police were called again because Brian had been found by a neighbour disorientated. The police escorted Brian to the Emergency department. When asked if he had any intention to end his life Brian replied, "My life is already over". Brian was discharged from the Emergency Department on 26th January 2021.

3.31. On 26th January 2021, Turning Point received a telephone call from a community pharmacy (which Brian used to obtain his prescribed methadone) concerned about Brian's mental health. Brian was sleeping outside the pharmacy on a bench, and they struggled to get him to leave. Turning Point told the pharmacy that an Adult Safeguarding concern had been raised with ASC.

3.32. On 30th January 2021, Brian was paying to live in a hotel in Chippenham, fearful of being in danger in his own flat from break-ins by neighbours. The police were called in response to concerns about Brian's behaviour. Brian was detained under s136 but did not need further assessment and was discharged home the next day with support from SIS. Brian did not attend subsequent appointments. Attempts were made with a family member to follow this up without success.

3.33. On 4th February 2021, Police contacted Brian's Care Coordinator to discuss a multi-agency meeting. A member of Brian's family also contacted the Care Coordinator voicing concerns that Brian needed extra support

3.34. On 5th February 2021, Brian attended Turning Point and was due to go again on 11th February.

3.35. On 7th February 2021, at around 4am Police attended since Brian was threatening a neighbour with a baseball bat. Brian calmed down but was noted to be paranoid about people trying to hurt him and said he was using drugs. Brian was assessed as at low risk of self-harm.

3.36. Later that morning, at around 10.15am a neighbour reported that Brian's flat was on fire. A neighbour told the ambulance service that Brian was seen at a window shouting for help. The fire service deployed a ladder in order to rescue Brian through the window, but found no signs of life. A decision was then made to leave Brian in the same position due to the development of the fire within his flat, the severity of his injuries and that he was unresponsive.

3.37. Once the fire had been extinguished and the smoke had been cleared an ambulance offer entered the flat and confirmed Brian was deceased.

4. THE EVIDENCE BASE FOR THIS SAFEGUARDING ADULTS REVIEW

4.1 The Local Government Association Analysis of Safeguarding Adult Reviews April 2017 – March 2019 section 3.4 "*Type of Reviews*" describes a number of "methodological" requirements and related shortcomings of SARs, which can be summarised as follows:

4.2 SARs should connect their findings and proposals to an evidence base. There is, for example, a considerable amount of practice guidance for how to work with people who self-neglect but few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.

4.3 SARs should be based on research. Over 50 Safeguarding Adults Boards have carried out SARs on the same set of circumstances on more than one occasion but have treated each discreetly. The SARs do not refer to each other, build on each other, or ask why it happened again.

4.4 SARs should be analytical. There is too much description and not enough analysis.

4.5 SARs should not shy away from difficult or sensitive topics. Few SARs engage in the legal and financial context of practice or decision making and should raise the impact of funding cuts, government strategy and reductions in services.

4.6 Consequently, this SAR will consider both the research and practice evidence for working with people who self-neglect in the context of alcohol and substance use.

4.7 Alcohol-use findings from safeguarding adults reviews

4.8 The Alcohol Change UK July 2019 report, "*Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017*", analysed 11 SARs and identified a number of themes common to all the reviews. Building on these, a further

SAR (Andrew, Staffordshire and Stoke, 2022) identified eleven themes. These eleven themes will be identified and the extent to which these were present in Brian's case will be considered in section 5. Further information is shown in Appendix 1.

4.9 **Self-neglect practice guidance**

4.10 Brian appears to have been self-neglecting. He was using drugs and alcohol which were likely have influenced his physical ability to self-care, he missed medical appointments and when the fire brigade was called to Brian's flat on the day he died they found high levels of hoarding inside and outside his flat.

4.11 Of especial relevance to Brian, whose mother had died in 2019, and whose son no longer lived with him from September 2020, the loss of a loved-one is one of the two most common experiences cited by individuals who self-neglect (the other is being a victim of violence) (Lien et al, 2016).

4.12 There is extensive research into, and guidance on, working with people who self-neglect largely but not exclusively produced by Suzy Braye, Michael Preston-Shoot and David Orr. How agencies worked with Brian will be considered in the context of this practice guidance. A summary of the guidance is shown at Appendix 2.

4.13 **Self-neglect, mental capacity and freedom of choice**

4.14 All the contacts with Brian took place within a policy context that emphasises choice, independence and personal control and which forms part of an overall neo-liberal Government led approach to adult social care and welfare (Ward et al, 2020).

4.15 This SAR recognises the challenges of practicing in a way which balances the principles of the freedom of choice and self-determination with duties, public expectations and moral imperatives of public services. Further information on this is shown at Appendix 3 and the Human Rights Act at Appendix 4.

4.16 **Mental capacity**

4.17 The Mental Capacity Act (see Appendix 5) applies to the decision making of persons with "an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors". In July 2020 Brian was diagnosed with ASD, which might meet the criteria for an impairment of the mind or brain. Brian was also using drugs and alcohol which can have a coercive and controlling influence on decision making and particularly on decisions related to substance use. The extent to which this was recognised in practice will also be considered.

4.18 **Decisional and Executive Capacity**

4.19 The ability a person who self neglects to act on their decisions should also be considered. In Brian's case there were concerns about his ability to self-care, and to become drug and alcohol free. Whilst the Mental Capacity Act does not explicitly

recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice. Further information is shown in Appendix 6.

4.20 **Repeated hospital attendances**

4.21 Brian attended the Emergency Department of the Great Western Hospital seventeen times between 19th September 2020 and 26th January 2021. Previous Safeguarding Adults Reviews (for example, that of Andrew, Staffordshire and Stoke, 2022 and Ms H and Ms I, London Borough of Tower Hamlets, 2020) have identified that repeated Emergency Department hospital admissions (and in Brian's case frequent attendances) are a potential warning sign of escalation in an adult's vulnerability (Jarvis et al, 2018) and that, for some adults at risk of abuse, hospital admissions may provide the only opportunity for safeguarding interventions to be made (Boland et al, 2014). These interventions should be made on a multi-agency basis and are more effective if they involve the vulnerable adult and their family as well as professionals.

4.22 Hospital admissions can also provide an opportunity for change: they can allow reflection, reconsideration and the engagement of other agencies and the use of different approaches and interventions (Boutin-Foster et al, 2005; Gersons, 1990).

4.23 **The Care Act 2014 and self-neglect**

4.24 If an adult refuses an assessment for care and support needs, then under Section 11 of the Care Act 2014, the local authority is not required to carry one out unless there are concerns about the adult's mental capacity to make the decision to refuse the assessment or that they are experiencing abuse or neglect (s11.29(b)). This includes self-neglect.

4.25 The Care Act makes provision to, and allows some flexibility in how to promote the wellbeing and meet the needs of adults who, like Brian, self-neglect.

4.26 After Brian's diagnosis of ASD he was offered a referral to ASC for a care and support needs assessment, but Brian did not wish to take up this offer.

4.27 **Fire risk**

4.28 The Dorset and Wiltshire Fire and Rescue Service Fire Investigation Report completed on 17th February 2021, after Brian's death, concluded that there had been high levels of hoarding inside and out of Brian's flat and that there was, "poor housekeeping present throughout", and, "access between rooms was also difficult". The report found:

4.29 "High of amount of items within Brian's bedroom and on top of the bed, suggesting that it had not been slept in for some time".

4.30 "There were a number of aerosol cans present in a number of rooms in the form of air freshener type, smoking materials and alcohol was also found within the kitchen.

4.31 “Candles and a lighter were found”.

4.32 “A bed was placed next to the living room door blocking access and entry. This was the seat of the fire”.

4.33 The report concluded that, “It is the considered opinion that the most likely cause was a fire of deliberate ignition involving combustible materials in the form of bedding and an ignition source such as a lighter, cigarette or candle”. The Coroner’s inquest concluded that Brian’s death had been accidental.

4.34 **Suicide and mental health needs**

4.35 Brian had mental health needs including anxiety, depression, Post Traumatic Stress Disorder, Obsessive Compulsive Disorder (which Brian said had been diagnosed in prison) and paranoia, which was in the context of drug induced psychosis. Brian was treated with antidepressants and was signposted to psychological therapy services. It was also considered that Brian had Emotional Unstable Personality Disorder (EUPD).

4.36 Suicide risk tends to increase with age. Brian was in the joint fifth highest risk group (40-44 years old, suicide rate of 11.9/1000). Some data on the risk of suicide is shown in Appendix 7.

4.37 **The Royal College of Psychiatrists – Risk factors and safety plan**

4.38 The Royal College of Psychiatrists’ Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020, sets out a number of “Risk factors and red flag warning signs” and recommends a safety plan. (See appendix 8).

4.39 **Suicide and the autism spectrum**

4.40 A recent SAR (Tyrone Goodyear, London Borough of Lewisham, 2020), highlighted that there was a small but growing body of research into suicide risk in adults with autism spectrum conditions and identified a number of factors which are shown in Appendix 9.

4.41 In summary and in terms of Brian, there is evidence that people with autism spectrum conditions are:

- At a greater risk than the general population are of suicide
- Have a different risk profile which includes previous attempts at self-harm and a number of life experiences including physical abuse, feelings of isolation and lack of support, having restricted patterns of thinking and lack of imagination, having unmet support needs and camouflaging/ concealing autism.

5. ANALYSIS

5.1. Using this research and practice evidence base it is possible to analyse the way in which the different organisations involved worked with Brian.

5.2. **Alcohol and substance misuse**

5.3. Brian, and the response of services to him, shared a number of characteristics with the cases identified in the Alcohol Change UK July 2019 report, "*Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017*" and the Stoke and Staffordshire "Andrew" SAR 2022. Each of these eleven characteristics is listed below under headings, and under each heading there is an exploration of the extent to which the characteristic was present in Brian's life or was present in services' response to him. Some of these eleven characteristics are particularly significant to Brian's life and / or correspond to other practice or research frameworks, and have been specifically analysed.

5.4. **Agencies' struggle to engage with Brian**

5.5. There is evidence that agencies struggled to engage with Brian. Between November 2019 and December 2020 Brian failed to attend several gastroenterology appointments, and there were periods during 2020 when his engagement with Turning Point was intermittent.

5.6. Brian did not wish to engage with interventions proposed by the ASD team In July 2020 and missed appointments with SIS in October 2020 and November 2020. The SIS also struggled to engage with Brian during the second period that he was on their caseload (16th January to 4th February 2021).

5.7. Brian did not attend follow-up appointments after his hip surgery on 11th January 2021, which may have had a detrimental effect on his recovery and on 1st February 2021 did not attend an appointment with his care coordinator and consultant psychiatrist. The following day Brian was due to attend a meeting handing over his care from the SIS to the Care Coordinator, but he jumped out of the taxi just as he and a family member were about to leave to attend the appointment.

5.8. **Self-neglect**

5.9. Self-neglect was first mentioned in the chronologies on 16th January 2021, when a risk assessment completed by AWP stated that Brian was at risk of self-neglect, substance misuse and from symptoms associated with a personality disorder and autism.

5.10. Brian's flat was first reported as cluttered on 18th January 2021. In Turning Point's safeguarding concern raised with SBC on 22nd January 2021, Brian was described as not meeting his self-care needs. Following Brian's death the fire service reported that there were high levels of hoarding in his flat and poor house-keeping.

5.11. **Exploitation of a vulnerable person**

5.12. There is no definite evidence that Brian was being exploited. On 17th October 2019, however, Brian attended the Emergency Department for self-poisoning telling hospital staff that he had been threatened by people if he did not take a concoction of medication. However, the Emergency Department believed the threat to be a

hallucination. In 2020 Brian reported that he wanted to get away from the drug dealers, who knew his address, so that he could be free of drugs. It is possible that the dealers were coercing him to take drugs. The letter from Brian's GP to the housing department stated that the drug dealers were harassing Brian.

5.13. **Domestic and Child abuse**

5.14. No information was gathered on Brian's childhood or any adult experiences of domestic abuse by the organisations that tried to work with him. Brian's GP had records of PTSD (Post-Traumatic Stress Disorder), but there is no detail on this and whether it was related to any abuse.

5.15. **Chronic health problems**

5.16. Brian had Barrett's oesophagus and was also listed in his GP's records as having Hepatitis C and as being HIV positive.

5.17. **Mental health conditions**

5.18. Brian was diagnosed with anxiety and depression, PTSD, and in the last months of his life he became increasingly more paranoid.

5.19. **Traumatic events triggering alcohol intake and drug use**

5.20. Whilst practitioners believed that the death of Brian's mother in 2019 had a detrimental impact on him, there seemed to be little exploration of events prior to 2019. Brian started taking drugs and misusing alcohol well before this, he first became involved with mental health services around 2010/11 presenting with anxiety and depression and from the age of 18 years old he was described as having obsessive compulsive disorder (OCD) traits and was diagnosed with PTSD in 1992. Brian's paranoia was considered to have been drug induced. There appears to have been no exploration with Brian himself, or with his family, of what had caused the trauma and the extent to which it affected him. If Brian's GP had explored these matters with Brian, it was not noted down. There was no exploration of Brian's life history or of what had led to Brian's excessive use of alcohol and drug taking. Brian's sister contacted his Care Coordinator in January 2021 concerned that Brian needed more support and this may have been an opportunity to have gathered some history.

5.21. **Lack of family involvement**

5.22. Brian's mother died at some point in 2019 and a second cousin died in October 2020. Brian had a sister and he had a cousin who supported him at times to attend appointments and advocated for Brian's housing needs. Brian and his partner had separated before the younger of his two sons was born.

5.23. Family involvement is a feature in both the Alcohol Change UK report of 2019 and in the guidance on working with people who self-neglect. Brian's sister was in contact with Brian's GP and also with Brian's care coordinator. Agencies identified that there

was some family support for Brian, although it is not clear exactly what that was, except that a cousin advocated for Brian about his housing situation. Agencies could have considered using family members in a more planned way by working with them as partners in considering and making interventions. What contact there was with family members does not appear to have been used to identify any other approaches that could have been employed to support Brian. Consequently, in terms of the guidance on working with people who self-neglect there little evidence of thinking flexibly about how family members and community resources can contribute to interventions, building on relationships and networks.

5.24. **High levels of alcohol intake and over-reliance on alcohol use to explain Brian's presentation**

5.25. Brian used illicit drugs and was considered to misuse alcohol, although there does not seem to be any recording of the amount of alcohol that Brian drank. There were occasions where it appeared that there was an over reliance on substance misuse to explain Brian's presentation. For example, in December 2020 a gastroenterologist wrote to Brian's GP stating "You are quite correct to highlight some lifestyle issues. Unless these are addressed, continuing surveillance and/or investigation of vague symptoms is unlikely to be of any significant benefit". More generally, clinicians believed that Brian's substance misuse caused or at least exacerbated his mental health presentation. According to AWP "There is an unmistakable pattern of Brian presenting with what appeared to be acute symptoms of psychosis, and these symptoms not being in evidence when he was assessed later, following sleep and the effects of alcohol and illicit substances wearing off".

5.26. This may have been an accurate description of what was happening at the time, but may have distracted attention away from exploring underlying mental health needs. AWP assessed Brian as not requiring detention in hospital, and continued with the services of the Intensive team, but the Intensive team struggled to engage with Brian.

5.27. This pattern of substance-induced psychosis does not appear to have been present on 19th January 2021 when Brian attended the Turning Point Hub. Staff were particularly concerned for Brian's mental state as he presented as "sluggish" and "sedated" and told Turning Point that he had been shot in the leg, yet when Turning Point tested Brian for drugs they found him to be drug-free. It appears that Brian's mental health deteriorated in the last month and a half of his life. His attendances at the Emergency Department were particularly frequent during this period and were all related to poor mental health. Turning Point raised a safeguarding concern with ASC, which contacted AWP, but this did not result in extra support or different interventions being used.

5.28. It is possible that agencies too readily accepted that drug and alcohol misuse were the cause of Brian's problems and did not explore what led Brian to use substances and, consequently, did not recognise the need to try different interventions.

5.29. **Regular contact with ambulance services (and the Emergency Department)**

5.30. Between 22nd September 2020 and 30th January 2021 Brian had contact with the ambulance service on eleven occasions. Brian attended the Emergency Department of the Great Western Hospital seventeen times between 19th September 2020 and 26th January 2021. Nine of these were between 26th December 2021 and 26th January 2022 (the last month and a half before Brian died). On four of these nine occasions Brian was admitted to the Emergency Department observation ward. Brian's attendances were for physical health symptoms, mental health needs or for a mixture of both. From 26th December 2020 attendances for mental health concerns increased, with six being for mental health symptoms, one for physical health complaints and two for both mental and physical health symptoms. This pattern suggests that Brian's mental health was deteriorating and in the latter weeks of his life Brian experienced greater paranoia. On the final hospital attendance before his death Brian presented as "suicidal" and said that his "life was already over".

5.31. Great Western Hospital had monitored Brian's Emergency Department attendances identifying him as at risk and created a high intensity user plan for him, which was good practice. Whilst GWH notified Brian's GP of this, it did not reach a wider, multi-agency audience and was not part of a framework or pathway that led to a multi-agency realisation of the risks.

5.32. **Unpopularity with the local community or having concerned neighbours**

5.33. There were reports of Brian being unpopular with neighbours because of his drug use and his antisocial behaviour. He was reported to have threatened neighbours, and this appears to be related to his paranoia.

5.34. **Summary of the analysis Brian's circumstances in relation to the Alcohol Change report and the Stoke and Staffordshire "Andrew" SAR**

5.35. Considered in the light of both the Alcohol Change UK 2019 report and other safeguarding adults reviews, Brian's case cannot be considered to be unusual or unique and his circumstances further confirm that the pattern already identified by Alcohol Change UK and in other reviews.

5.36. Of the eleven factors listed above at least eight of them applied to Brian, and the other three may have been present but insufficient detail is known. This pattern of circumstances might be predictive of poor outcomes unless different approaches are taken. In consequence, services should consider how the presence of this pattern of characteristics might be identified in the future and how this might lead to interventions that result in better outcomes.

5.37. **Operational realisation of Brian's diagnosis of autism spectrum disorder**

5.38. Following a referral from his GP in July 2018, Brian was diagnosed with ASD in July 2020, having attended autism assessments in January and March 2020. This diagnosis was comparatively late in life as Brian would have been about 42 years old at the time. Due to broadening of diagnostic criteria, social camouflaging and increased awareness, the late diagnosis of ASD is not unusual.

5.39. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), used to diagnose Brian defines autism spectrum disorder as “persistent difficulties with social communication and social interaction” and “restricted and repetitive patterns of behaviours, activities or interests” (this includes sensory behaviour), present since early childhood, to the extent that these “limit and impair everyday functioning”.

5.40. The Specialist Learning Disability and Autism Diagnostic Service, which carried out the assessment and gave the diagnosis, is commissioned only to provide diagnostic input. Specialist ongoing treatment services for clients with ASD are not currently commissioned in Swindon.

5.41. The diagnostic service made some recommendations for Brian, including engaging with LIFT Psychology and being referred to the local authority for a Care Act assessment. Brian did not wish to engage with these interventions. The diagnostic service also completed a hospital passport for the Brian, which was intended to aid his interactions with healthcare staff. There is evidence that the Great Western Hospital were aware of Brian’s ASD diagnosis from at least 17th October 2020, but it is not clear if they were aware of the hospital passport. It is unknown if Brian carried the passport with him.

5.42. It seems that other services were not aware of Brian’s ASD diagnosis, and therefore there was no specific consideration of how they might have responded to Brian in a way which took account of his needs.

5.43. If services (other than the ASD Team and the hospital) did not know about Brian’s ASD, they could not consider this as an impairment in the functioning of brain or mind in mental capacity assessments. On 11th January 2021 the hospital had created the high intensity user plan to be followed when Brian attended the Emergency Department. This listed “autism” as one of Brian’s “clinical problems” and advised staff to test mental capacity should Brian decline clinical investigations or treatment. It is not clear however to what degree ASD was factored into the mental capacity assessments.

5.44. Brian could be verbally abusive to people including staff. There does not appear to be any exploration of the extent to which ASD was a factor in Brian’s behaviours, in his association with criminality or whether Brian was manipulated by others.

5.45. In January 2021 Brian was referred to a dual diagnosis link worker. This was for a dual diagnosis of substance dependency and mental health needs. There was no consideration of how Brian’s autism and mental health concerns could be managed in tandem, nor indeed consideration of how best to support someone with a triple diagnosis of ASD, mental health needs and substance dependency.

5.46. In summary there was little or no operational realisation of Brian’s diagnosis of ASD.

5.47. **Contact between agencies and multi-agency working**

5.48. There were multiple agencies involved with Brian: Turning Point, various teams within AWP (including the Autism Spectrum Disorder Team, the Intensive Team and

the Recovery Team), the police, the ambulance service, Great Western Hospital, SBC Housing Department, SBC social services which received the 22nd January 2021 safeguarding referral, the Probation Service and Children's Services.

5.49. Brian's GP practice was aware of Brian's involvement with both mental health services and drug treatment services and identified as part of this review that it was not involved in conversations about Brian and his interactions with these services. Brian's GP practice was made aware of safeguarding concerns raised about Brian but did not raise its own adult safeguarding concerns, which may have added weight to the discussions about Brian.

5.50. Turning Point reported good communication at the time with and between the probation service, Brian's GP and community mental health services (AWP). However, when Turning Point raised a safeguarding concern with SBC on 22nd January 2021, Brian was at a hotel in Chippenham at the time. Chippenham is in Wiltshire Council's area. SBC have acknowledged that they should have passed information to Wiltshire Council's Safeguarding Team, and that they had relied on AWP's responsibility for a wider area which included Chippenham.

5.51. No multi-agency meetings were held, which may have enabled all the agencies to pool their knowledge of Brian and to generate new and co-ordinated approaches to engage him to meet his complex needs. There were events that could have triggered a multi-agency meeting, for example the safeguarding concern raised by Turning Point with SBC on 22nd January 2021. The Police contacted the SIS on 4th February 2021 to suggest taking a multi-agency approach to working with Brian, who died three days later. This pattern of too slow recognition that current approaches are not working and of the need for multi-agency sharing of information and coordination of action is present in other SARs (Evelyn, Richmond and Wandsworth (2021), Thomas, Walsall, (2022) and Andrew, Staffordshire and Stoke, 2022).

5.52. No one agency took on case leadership for instigating joined-up multi-agency inventions. Various agencies had tried to meet Brian's needs and for example, Turning Point made active attempts to reengage with Brian but knowledge sharing was fragmented in places so that no one had a full picture of Brian. The lack of a multi-agency approach is significant because it appears that no one agency had sufficient knowledge of Brian to meet his complex needs and protect him from harm on their own.

5.53. **Risk assessment**

5.54. On 29th September 2020, whilst detained under section, Brian poured boiling water over another patient. The police were advised that Brian lacked mental capacity and took no further. Three days later, on 2nd October 2020, Brian's section 2 detention ended and he was transferred to the PICU until 16/10/20. AWP's records do not show under which section(s) of the Mental Health Act Brian was detained whilst in the PICU.

5.55. On 30th October 2020 the High Intensity Team at the Emergency Department wrote to Brian's GP advising that Brian was a high intensity user of the Emergency

Department, a group more at risk and likely to have unmet care needs. This letter was received but there is no evidence on the GP records of any response to this.

5.56. According to AWP eight risk assessments were completed for Brian between 22nd September 2020 and 16th January 2021. In five of these, i.e.: on 22nd September 2020, 30th September 2020, 19th November 2020, 9th January 2021 and 16th January 2021, there are some specific risks noted variously to self and/or to others, categorised in one case as "medium" risk and in the remaining cases "high" risk, however in most cases there is no overall risk assessment rating given. The risk assessments contained both historical and current risks, although it is difficult to determine one from the other. It is also difficult to identify risks within the assessments. For example the risk assessment on 16th January 2021 stated that Brian "was reluctant to engage in treatment and support from services, he had an extensive forensic history and was under probation. He also presented with some paranoid thoughts about others wanting to harm him", and, "At the time of the risk assessment…was reported to be experiencing thoughts of hurting those he believed were tracking him". Despite this AWP subsequently concluded that there was no risk of harm to others. Brian was deemed to be at "medium" risk of self-neglect, substance misuse and from symptoms associated with a personality disorder and autism.

5.57. On several occasions, the police were called when Brian had allegedly been threatening towards others, but the police viewed Brian as not at risk of harming others. Although AWP stated as part of the review that there was contact between the police and mental health services about incidents, and that some risks were shared with the police via the Mental Health Control Room Triage team, AWP were unable to confirm whether the contents of the risk assessment on 16th January 2021 were shared with the police.

5.58. It is not clear exactly what the police were told, and, if they had been made aware that Brian was a "high" risk to others, what they were expected to do. AWP stated during the review that if Brian has been violent then it would have expected the police to have taken Brian to a place of safety for assessment by mental health services. This does not, however, cover what the police would do in response to the risk that Brian might be violent.

5.59. On 4th February 2021, shortly before Brian died, the police emailed AWP to inform them that Brian was making residents feel scared, and to request a multi-agency approach be used.

5.60. AWP considered that Brian's psychotic symptoms were caused by or made worse by substance misuse. There were several occasions when Brian's psychotic symptoms were reported to have disappeared with sleep and once the effects of drugs and alcohol had worn off. The ward consultant in the PICU described Brian's presentation as more consistent with personality disorder than psychosis. Brian had already been considered to have EUPD.

5.61. In light of this it is possible that Brian was more at risk of self-harm and of harming others when he was under the influence of drugs and/ or alcohol. Any risk

assessments completed when Brian was sober may have underestimated the risk in general. The risk assessment completed in January 2021 does not differentiate between an intoxicated state and a sober state. Given that Brian appeared to continue to misuse substances, agencies' struggled to engage with him, and that he had attacked others and harmed himself in the past, there most likely would have been a risk of future episodes of drug taking/ alcohol intoxication during which he may harm others or himself.

5.62. In summary GWH had identified that Brian was potentially at high risk due to his frequent Emergency Department attendances and that he was a high intensity user, but this does not appear to have led to different responses by agencies or, more importantly, to a co-ordinated multi-agency response. AWP completed risk assessments, but they did not consider whether the risk fluctuated depending on circumstances (such as substance intoxication) and how occasions of heightened risk could be mitigated. During AWP's risk assessment on 16th January 2021, specific examples of risk to others were rated as "high", yet according to AWP no overall risk rating was given. AWP are unable to explain why the specific examples did not translate to an overall risk rating of "high". Disengagement from services should also be considered as a risk factor in and of itself. People who engage with services are less likely to become the subject of safeguarding adult reviews.

5.63. **Risk of suicide and a safety plan**

5.64. Brian had a history of self-harm and of presenting as suicidal. Brian also had a history of overdose dating back to 1990. Brian deliberately overdosed on prescribed medication in 2008 and, it would appear, again on 7th July 2019.

5.65. On 16th July 2019 Brian attended the Emergency Department and was described as suicidal and wanting to overdose. Brian said his mother had been diagnosed with a terminal illness, that he was feeling low, but had no intention of taking his life.

5.66. On 22nd September 2020 Brian was found at a train station with thoughts to end his life. He had a bag with a rope and the AWP note of this incident stated, "Risk of suicide by hanging …impulsive behaviour when under the influence of illicit substances". This resulted in Brian being assessed and detained under section 2 of the Mental Health Act. However, the notes from the following day (23rd September) reported no current thoughts of self-harm or suicide. Yet in the notes from the next day (24th September) and then on 29th September and 1st October thoughts of self-harm are again noted

5.67. This pattern of fluctuation continued. On 17th October 2020 Brian attended the Emergency Department with his cousin for self-poisoning. Brian said that he had been threatened by people if he did not take a concoction of medication. The Emergency Department believed the threat to be a hallucination.

5.68. On 18th October 2020 the Mental Health Control Room Triage considered Brian to be at risk to himself as he had thoughts of self-harm and suicide. However, on 20th October 2020 Brian told the Mental Health Liaison team at GWH that he had never been a "suicide person" and acknowledged that he had lots to live for, including his

son. Despite this, on 23rd October 2020 Brian told his cousin he was going to overdose on methadone. The following day Brian was found collapsed and admitted to the Emergency Department observation ward. On 25th October Brian discharged himself.

5.69. On 9th January 2021, whilst in the Emergency Department, Brian threw himself to the floor, fracturing his hip. Brian told SIS on 14th January 2021 that he had no suicidal or self-harm thoughts but on 26th January 2021 Brian attended the Emergency Department with suicidal thoughts. When Brian was asked if he had any intention to end his life Brian stated, "My life is already over".

5.70. The risk assessment on 16th January 2021 did not specifically mention suicide but concluded that Brian was at risk of self-neglect, substance misuse and from symptoms associated with a personality disorder and autism. No suicide safety plan appears to have been considered and development of one with Brian may have provided strategies for him to cope with suicidal thoughts.

5.71. From the history noted above it appears that Brian's thoughts alternated between suicidal and non-suicidal, sometimes within a few days. Two mental health practitioners considered that Brian had a personality disorder which was associated with impulsivity. Research has highlighted a positive association between impulsivity, difficulties with emotion regulation and suicidal acts (Bilsen, 2018). The move from contemplation of suicide to suicide attempts and then to completed suicide can occur suddenly (Apter and Wasserman, 2006).

5.72. Given what is known about the rapidity with which suicidal intention can turn into suicidal acts, it would appear appropriate for a safety plan to have been drawn up as a contingency, rather than to have focused on trying to categorise risks. As the Royal College of Psychiatrists' report says, "…any patient with suicidal thoughts or following self-harm needs a Safety Plan".

5.73. The coroner determined that there was insufficient evidence for a verdict of suicide.

5.74. Emotionally Unstable Personality Disorder Treatment and input from AWP

5.75. Brian was considered by two mental health practitioners to have a personality disorder. These are noted during Brian's stay in the PICU in October 2020 and on 17th January 2021 during a mental health assessment. Systems Training for Emotional Predictability and Problem Solving (STEPPS) has been found to be effective for EUPD https://pubmed.ncbi.nlm.nih.gov/21389754/. NICE state other therapies may be helpful including dialectical behavioural therapy (BDT), Mentalisation-Based-Therapy (MBT) and Schema therapy https://www.nice.org.uk/guidance/cg78. None of these therapies were tried with Brian. However, whilst in the PICU Brian was involved in some group sessions on the ward with therapy staff and there was some discussion around methadone therapy, which he was prescribed.

5.76. **Hoarding**

5.77. Brian's Care Coordinator visited Brian on many occasions but did identify that Brian was hoarding although the house appeared to be cluttered at times. On 19th November 2020 the Care Coordinator visited Brian but did not notice any clutter. The first time Brian's flat was described as untidy was on 18th January 2021. The Fire Brigade concluded after the fatal fire on 7th February 2021 that there had been high levels of hoarding inside and outside Brian's flat and that there was "poor housekeeping present throughout".

5.78. It appears that there is a need for a better understanding of hoarding and recognising the need for intervention. Swindon Safeguarding Partnership has recently revised its hoarding protocol which will soon be launched with policy and guidance on responding to self-neglect and hoarding.

5.79. **Handling of safeguarding concerns**

5.80. On 16th January 2021 SWASFT made raised a safeguarding concern, which was received on 21st January 2021 by the SWB safeguarding team, and were notified that there would be no action since Brian was under the care of AWP.

5.81. On 22nd January 2021 Turning Point submitted a safeguarding concern to Swindon Borough Council Safeguarding Team. The referral stated that Brian was not meeting his self-care needs, that his mental health was extremely poor, that he believed people outside his flat were threatening him and that police and other people were trying to shoot him/had shot him. The Safeguarding Team interpreted this as a decline in Brian's mental state, as did the referrer. The Safeguarding Team gathered further information about the concern and understood that care coordination was in place, through AWP, to provide a response to the apparent deterioration in Brian's mental health.

5.82. The referral also contained information about Brian's mobility. Brian had fractured his thigh bone ten days previously and said that consequently he was unable to wash himself or to clean his flat. Whilst Brian's deteriorating mental health may have had a detrimental impact on his self-care, there was also a reported physical ailment which had a similar effect. The emphasis of the safeguarding concern on mental health did not seem to recognise this or that psychiatric interventions may not result in an immediate improvement in Brian's mental health, and consequently his motivation to self-care and do house-work. Nor did it recognise that Brian may not have been physically able to look after himself because the fracture. This may have been a missed opportunity to offer a Care Act assessment of Brian's for care and support needs. On 13th January 2021 a police officer had attended Brian's home and reported that Brian did not have the capacity to be at home and that Brian did not think he could cope. This suggests that Brian may have accepted help at this time.

5.83. The safeguarding referral from Turning Point was closed after screening on the basis that a care coordinator from AWP was in place who said that Brian's case would be escalated and Brian was staying in Chippenham at the time of referral (i.e. outside of Swindon Borough Council's area). The referral had highlighted Brian's worsening mental health which was deemed to be better addressed by a mental health assessment as opposed to a section 42 safeguarding enquiry.

5.84. On 26th January 2021, Turning Point received a telephone call from Brian's pharmacy concerned about Brian's mental health. Brian was sleeping outside the pharmacy on a bench, and they struggled to get him to leave. The pharmacy was told that an Adult Safeguarding concern had already been raised. However, the previous day, Turning Point had received an email from the Adult Safeguarding team explaining that the concern had not proceeded to a section 42 enquiry.

5.85. **Brian's family and housing**

5.86. The eldest of Brian's sons, who was 15 years old in 2020 and living with Brian at the time (it is not clear how long he had been living with Brian) became subject to a Child in Need (CIN) plan from 7th May 2020. A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled. Brian received support from Children's Services to care for his son until 22nd September 2020 when Brian was detained under the Mental Health Act. Brian's son then lived with his grandmother until October 2020 and then with Brian's sister. SBC Housing Department were notified of this. Brian's son was advised by his mother, via a social worker, not to see his father due to the instability of his mental health.

5.87. Practitioners believed that the death of Brian's mother had a damaging effect on Brian's mental health. The extent to which not having access to his son, nor being able to live with his him impacted on Brian is not known. Brian may have felt a sense of loss and this may have affected his mental health and increased his substance use. Brian wanted to see his son.

5.88. Brian lived in a first floor one bedroom flat. On 6th May 2020 SBC Housing Department received an application from Brian to be rehoused with his eldest son. His application was assessed on 1st July 2020 and Brian submitted bids for two-bedroomed properties 17 times and on each occasion he was unsuccessful. In Swindon it can take on average 18 months to secure a two-bedroom flat.

5.89. On 29th October 2020 Brian talked with his GP about his eldest son. Brian reported that he was keen to stay in touch with his son and did not want to "give him up". He said that he wanted to come off drugs so that contact with his son would be possible. Brian asked his GP for a letter for the Council to persuade them to rehouse him, reporting that drug dealers knew where he lived and he did not want to return there.

5.90. Brian asked to move home on medical grounds. On 18th November 2020 the Housing Department received a letter from Brian's GP stating that Brian was reluctant to return to his flat because he was being harassed by previous drug suppliers and that he was keen to move as soon as possible. The Housing Department advised its tenancy services team to seek evidence of all Brian's medical conditions which directly had an impact on his physical health, so that his rehousing application could be reassessed. According to the housing department, rehousing on

medical grounds may be granted for either physical health or mental health reasons, but applications must be supported by relevant professional evidence, and show that housing is having an adverse effect on the individual's health.

5.91. On 24th November 2020 Tenancy Services advised the housing department that they would support Brian to find a property exchange because he wanted to move out of Swindon, even though he did meet the criteria of having held a tenancy for one year and not being in rent arrears. Tenancy Services advised Brian's son and his social worker about how he could apply. However, on 26th November 2020 Brian's housing application was suspended because he was not eligible for a two-bedroomed property and the housing department were awaiting medical evidence to consider his eligibility to move on medical grounds.

5.92. Tenancy services contacted Brian's GP who responded giving information on how Brian was feeling and tenancy services kept in regular contact with Brian's Community Psychiatric Nurse (CPN), but it appears this produced insufficient medical evidence.

5.93. The housing department had also advised that Tenancy Services and the police should investigate if Brian was being threatened by drug suppliers. In cases where there is an alleged risk to life or of serious injury Tenancy Services would expect the Police to support any urgent move request. Tenancy Services liaised with the police, but there was insufficient supporting evidence of threat to life or of serious injury and therefore the police could not support a move.

5.94. An exploration of Brian's feelings around contact with his son and a multi-agency meeting (to include housing) at this point may have produced a more co-ordinated response to Brian's complex needs. A professionals meeting was arranged for 15th February 2021 and was to include the police, the CPN and the housing department, to discuss how the case could be moved forward, but Brian died before this time.

5.95. **Mental Capacity**

5.96. It is unclear whether practitioners considered the impact of Brian's diagnosis of ASD, or were aware of and considered the effect of substance dependency, on his mental capacity. Substance dependency can be considered to have a coercive and controlling influence on the capacity to make decisions (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/467398/Pt1_Mental_Capacity_Act_in_Practice_Accessible.pdf and London Borough of Croydon -v- CD [2019] EWHC 2943 (Fam)) and can be the cause of the impairment in the functioning of mind and brain, which forms one part of the test of mental capacity.

5.97. On 27th December 2020 a discussion took place between the Mental Health Crisis Recovery Team (MHCRT) and the police highlighting that Brian may have been at risk from an overdose of heroin but he was presenting with capacity. According to AWP, Brian appeared to have a good level of insight as he was able to retain, understand and repeat information given to him. It was concluded that he appeared to have capacity to make decisions about his care.

5.98. Even if Brian had capacity to make decisions about his care the need to intervene to protect life under the Human Rights Act (article 2) should also have been considered.

5.99. Not all mental capacity assessments were clear about which decisions were being assessed. For example, on 8th January 2021 Brian attended the Emergency Department because he wanted to hurt or kill someone. He was admitted to the Emergency Department observation ward and a Mental Capacity Act assessment was completed which determined that he lacked capacity (to make which decisions is not recorded). Brian fractured his hip whilst in hospital and a further mental capacity assessment was made prior to his hip operation on 11th September. It is not clear from the hospital records, but it seems likely that this further assessment was to establish Brian's capacity to consent to the hip operation.

6. THE EXTENT TO WHICH PRACTICE WITH BRIAN WAS CONSISTENT WITH GUIDANCE ON WORKING WITH PEOPLE WHO SELF-NEGLECT

6.1 There was evidence that Brian self-neglected. The extent to which the services involved with Brian applied the guidance on working with people who self-neglect in practice should be considered.

6.2 Trauma informed approaches and seeking to understand impact of life experiences for self-neglect

6.3 Brian's GP described Brian as clearly having previous traumatic life experiences, which impacted significantly on his ability to deal with people and the world around him. The GP said Brian was not specific about what these life these experiences had been, but references had been made in previous assessments to traumatic experiences in prison and to childhood abuse. The GP recorded that Brian had post-traumatic stress disorder (PTSD), first identified in 1992 and had been signposted to psychological therapy services for this. On 24th October 2020 Brian was found unresponsive outside his mother's house, who had died one to two years previously and on 27th December 2020 Brian presented to Great Western Hospital with a deterioration in his mental health and told staff that he was struggling with the death of his mother. There does not appear to be any record that the GP explored Brian's life experiences and reasons for PTSD. Nor does this information appear to have shared with other agencies.

6.4 AWP have advised that they used trauma-informed approaches with Brian. Information on trauma-informed approaches is shown at Appendix 10. As well as the SIS team, Brian received support from the Recovery Team. Recovery teams provide care, treatment and support to adults with a variety of mental health needs, including mood disorders, anxiety disorders, psychosis and personality disorders. Teams carry out an assessment and work with service users to develop an individual care plan, risk management plan and crisis plan to support their journey through mental health services. Recovery teams work closely with GPs. A care plan was created which briefly covered the risk management plan and crisis plan. The Care Coordinator was involved in speaking with Brian s family and engaging with

other professionals, monitoring medication use, and in discussions around drug testing, housing, support and attendance at meetings including probation.

6.5 There was considerable evidence of working *patiently at the pace of the individual* with Brian who was not pressured or persuaded unduly. Turning Point worked proactively to engage with Brian, but otherwise agencies had not drawn together the collective intelligence to recognise the need to spot and *make the most of moments of motivation to secure changes.* For example, on 13th January 2021 a police officer reported that Brian did not think he could cope. This suggests that Brian may have been more accepting of help at this time. The ambulance service made a referral to adult social care and an occupational therapist tried to contact Brian but found that they had been given an incorrect contact number. ASC could have asked Brian's care coordinator for the correct details.

6.6 Exploration of legal options for working with Brian and understanding of Brian's mental capacity to make decisions

6.7 There were a number of Mental Health Act assessments, one of which resulted in Brian being detained at Green Lane Hospital and then subsequently in a PICU. Hospital staff were advised to routinely assess Brian's mental capacity when Brian refused treatment or clinical investigations, so there were attempts to ensure that *options for intervention were rooted in a sound understanding of legal powers and duties and there was* evidence of keeping constantly in view t*he question of the individual's mental capacity to make self-care decisions*. However, the effects of substance misuse on mental capacity may not have been recognised.

6.8 Communication about risks and options

6.9 There is insufficient detail given in the accounts of the interactions that agencies had with Brian to determine whether *risks and options were communicated to Brian with honesty and openness.*

6.10 Engagement of family members

6.11 Agencies could have considered working with family members in a more planned way by working with them as partners in considering and making interventions. Consequently, there little evidence of thinking *flexibly about how family members and community resources can contribute to interventions, building on relationships and networks*.

6.12 Multi-agency working with Brian

6.13 Whilst agencies did try to work together, there was little active work to *engage and co-ordinate agencies with specialist expertise to contribute towards shared goals*. There was a multiplicity of organisations involved and there was some inter-agency information sharing and communication. Despite this, few interventions and interactions were coordinated at any level above that of individual case work.

6.14 Case leadership and ownership of responsibility for meeting Brian's needs

6.15 There does not appear to have been an overall direction to the work with Brian or prompts and instructions to use the self-neglect pathway.

6.16 In summary, some of the key components of effective practice with people who self-neglect were either not applied or were applied insufficiently.

6.17 Good Practice

6.18 Turning Point took active steps to reengage with Brian when he disengaged with them. On 19th January 2021 Turning Point recognised that Brian was in need of help and were concerned about his mental health. The ambulance took some time to arrive and the clinician at Turning Point provided support to Brian and Turning Point staff while they waited for the ambulance. Turning Point also raised a safeguarding concern with SBC.

6.19 SBC advised Turning Point that they had closed the safeguarding referral that they had made in January 2021. It is good practice for safeguarding teams to feed-back outcomes to referring agencies.

6.20 Great Western Hospital notified Brian's GP that Brian was a high intensity user of the Emergency Department, suggesting that he may be more at risk and that his pattern of attendance may signify unmet care needs. Using data to identify people who might be at heightened risk is good practice.

6.21 AWP have advised that they used trauma-informed approaches with Brian

7. CONCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

7.14 Although GWH were aware of Brian's ASD diagnosis, apart from AWP, no other services appear to have been made aware of it. This would have been a barrier to considering how they might have responded to Brian in a way which took account of his needs. It also meant that other agencies would not have taken account of ASD in considering Brian's capacity to make decisions. (See Finding 3)

7.15 Risk assessments

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

7.17 The risk of suicide did not lead to a safety plan

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

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

7.20 Staff understanding of hoarding could be improved

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

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

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

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

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

7.26 It appears that practitioners were unaware that people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to

predict what might happen but are less likely to be able to take action to prevent it from happening. This understanding was not applied in assessing Brian's mental capacity. (See Finding 5)

7.27 Effective practice for working with people who self-neglect

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

7.29 The following are provisional depending on receipt of further information:

8. FINDINGS

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

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

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

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

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

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

APPENDIX 1: Alcohol use findings from SARs

The Alcohol Change UK July 2019 report, "*Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017*", analysed 11 SARs and identified a number of themes common to all the reviews. Building on these, a further SAR (Andrew, Staffordshire and Stoke, 2022) identified eleven themes, which are:

- Non-engagement with services
- Self-neglect
- Exploitation of a vulnerable person
- Domestic and child abuse
- Chronic health problems
- Mental health conditions
- Traumatic events triggering alcohol intake
- Lack of family involvement
- high levels of alcohol intake and over-reliance on alcohol use to explain the adult's presentation
- regular contact with ambulance services and
- unpopularity with the local community or concerned neighbours

The Alcohol Change UK July 2019 report also identified several practitioner perceptions that affected the way that services responded to these themes:

- Behaviours were seen as personal choice
- The extent of alcohol consumption was underestimated
- Lack of service capacity
- Commissioning of services so that they are available and effective
- High thresholds for support and for safeguarding concerns
- Understanding of the Mental Capacity Act and legal literacy

APPENDIX 2 Self-neglect practice guidance

Self-neglect can be defined as, "*the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecter and perhaps even to their community*" (Gibbons et al, 2006, p.16). Self-neglect is one of the ten categories of abuse and neglect specified in the adult safeguarding sections of the Care Act statutory guidance.

A summary of the practice guidance on working with people who self-neglect produced by Suzy Braye, Michael Preston-Shoot and David Orr is set out below.

The guidance is that practice with people who self-neglect is more effective where practitioners:

- Seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience

- Work patiently at the pace of the individual, but know when to make the most of moments of motivation to secure changes
- Keep constantly in view the question of the individual's mental capacity to make self-care decisions
- Communicate about risks and options with honesty and openness, particularly where coercive action is a possibility
- Ensure that options for intervention are rooted in a sound understanding of legal powers and duties
- Think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks
- Work proactively to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals.

In order to do this, the following approaches should be used:

- History taking. Explore and ask questions about how and when self-neglect started
- Be proactive and identify and address repeated patterns of behaviour
- Try different approaches, use advocates (of all kinds, including friends, formal advocates for particular functions including Care Act advocates and community, citizen and peer advocates) and concerned others, raise concerns, discuss risks, maintain contact, avoid case closure
- Ongoing assessment and review of mental capacity.

The policy, procedural and organisational environments that foster effective ways of working are likely to have the following characteristics:

- Agencies share definitions and understandings of self-neglect.
- Interagency coordination and shared risk-management is facilitated by clear referral routes, communication and decision-making systems
- Longer-term supportive, relationship-based involvement is accepted as a pattern of work.
- Training and supervision challenge and support practitioners to engage with the ethical challenges, legal options, skills and emotions involved in self-neglect practice.

APPENDIX 3: Self neglect, mental capacity and freedom of choice

Safeguarding Adults Reviews (amongst others Andrew, Staffordshire and Stoke, 2022; Harold, Brent 2022; Adults B and C, South Tyneside; Mr I, West Berkshire and W, Isle of Wight) have increasingly focused on the challenges of practicing in a way which balances the principles of freedom of choice and self-determination with the duties, public expectations and moral imperatives of public services. These take place within a legislative context that includes the Human Rights Act 1998, the Care Act 2014, the Mental Capacity Act and the Mental Health Act 1983.

At the intersection of all these factors is the question of the extent to which adults should be left by public services to behave in a way that is objectively detrimental to their health and wellbeing or which threatens their lives. More fundamentally it is question of prioritising

freedom of choice or prioritising protection from harm (essentially Articles 8 and 2 of the Human Rights Act 1998). The guidance on working with people who self-neglect helpfully challenges the either/ or nature of this question by asking practitioners to consider:

Is a person who self neglects really autonomous when:

a) They do not see how things could be different.
b) They do not think they are worth anything different.
c) They did not choose to live this way, but adapted gradually to circumstances
d) Their mental ill-health makes self-motivation difficult.
e) They have impairment of executive brain function.

Is a person who self neglects really protected when:

a) Imposed solutions do not recognise the way they make sense of their behaviour.
b) Their 'sense of self' is removed along with the risks.
c) They have no control and no ownership.
d) Their safety comes at the cost of making them miserable

APPENDIX 4: Human Rights Act

All public sector bodies, whether or they are directly or indirectly funded by the UK Government have a duty under the Human Rights Act to discharge the State's positive obligations under the European Convention on Human Rights:

- Article 2 – to protect life
- Article 3 – to protect against torture, inhuman or degrading treatment
- Article 5 – to protect against unlawful interferences with liberty, including by private individuals
- Article 8 – to protect physical and moral integrity of the individual (especially, but not exclusively) from the acts of other persons

APPENDIX 5: Mental Capacity Act

The Mental Capacity Act requires a three-stage test of capacity to make decisions:

1. Is the person unable to make the decision? i.e. are they unable to do at least one of the following things:
   - Understand information about the decision to be made, or
   - Retain that information in their mind, or
   - Use or weigh that information as part of the decision-making process, or
   - Communicate their decision (by talking, using sign language or any other means)

2. Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors such as alcohol or drug use?

3. Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to? Individuals can lack capacity to make some decisions but

have capacity to make others, so it is vital to consider whether the individual lacks capacity to make a specific decision at a specific time.

APPENDIX 6: Mental capacity - Decisional and executive capacity

There is growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation) which in turn impacts on mental capacity. Of relevance is that, compared with control groups, people with frontal lobe damage caused by alcohol use and traumatic experiences:

- Are significantly slower and less accurate at problem solving when it involves planning ahead.
- Persisted with riskier behaviours for longer and were less responsive to negative outcomes.
- Were no different when identifying what the likely outcome of an event would be.

As a result, people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening.

Significantly, these cognitive deficits are unlikely to be detected using the verbal reasoning tests frequently used in mental capacity assessments.

The proposed revised Code of Practice for the Mental Capacity Act will, subject to consultation, include guidance on assessing mental capacity where there is an impairment in executive functioning and a mismatch between what a person says and what they do and that, "A person who makes a decision which others consider to be unwise should not be presumed to lack capacity. However, a series of unwise decisions may indicate an inability to use or weigh information" (section 4.39).

APPENDIX 7: Suicide Risk

Most people who have depression do not die by suicide but having major depression does increase suicide risk compared to people without depression. Longitudinal studies have found that two percent of people who have ever been treated for depression in an outpatient setting will die by suicide (for people treated in an inpatient hospital setting, the rate of death by suicide is twice as high).

Given that at least 96% of people with depression do not die by suicide, an alternative way of considering suicide risk and depression is to examine the lives of people who have died by suicide and to identify the proportion who were depressed. From this perspective, it is estimated that 60 percent of people who died by suicide had a mood disorder (for example depression or bipolar disorder).

Up to 10% of people with borderline personality disorder (BPD)/ Emotionally Unstable Personality Disorder (EUPD) die by suicide (Paris, 2019), which potentially makes the presence indicators of BPD/ EUPD more predictive of suicide than indicators of depression are.

APPENDIX 8: Royal College of Psychiatrists Patient Safety Report

The Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020, sets out a number of "Risk factors and red flag warning signs".

These risk factors and red flags were specifically formulated for use in primary care settings. The report cautions that risk should be assessed on an individual basis and that the absence of risk factors does not mean the absence of any risk of suicide: "*…a person may be imminently at risk of suicide even though they are not a member of a 'high-risk' group. Conversely, not all members of 'high-risk' groups are equally vulnerable to suicide. Moreover, suicidal thoughts (and risk) can vary across a relatively short time period".*

The report states that, "*…any patient with suicidal thoughts or following self-harm needs a Safety Plan. No one is ever ineligible for an intervention and Safety Plan*" and that, "*If there are red-flag warning signs/immediate risk of suicidal behaviour, the patient will require*":

- Immediate discussion with/referral to mental health services
- A robust Safety Plan
- Adequate support
- Removal of access to means

A Safety Plan is an agreed set of activities, strategies to use and people and organisations to contact for support if someone becomes suicidal, if their suicidal thoughts get worse or if they might self-harm. The components of a Safety Plan are:

- Reasons for living and/or ideas for getting through tough times
- Ways to make your situation safer
- Things to lift or calm mood
- Distractions
- Sources of support, to include anyone you trust

There is emerging evidence of the effectiveness of safety plans (Zonana et al. 2018) and it is important that Safety Plans are co-created with patients and encourage communication with family and friends.

APPENDIX 9: Suicide and Autism Spectrum

A recent SAR (Tyrone Goodyear, London Borough of Lewisham, 2020), highlighted that there was a small but growing body of research into suicide risk in adults with autism spectrum conditions and identified the following factors:

People with autism spectrum conditions have a higher rate of mortality and of suicide than the general population does.

People with autism spectrum conditions have a different risk profile for suicide compared with the general population. This includes:

A history of self-harm but not of alcohol use

Negative life experiences including:

Adversity and conflict, being victimised or bullied

- Physical or sexual abuse
- Repeated failures to develop relationships
- Depression and other mental health problems
- Isolation due to lack of social support.
- Having difficulties coping with these experiences including:
- Behaviour problems (oppositional, aggressive, angry, explosive, and impulsive behaviours),
- Having restricted patterns of thinking and lack of imagination
- Having unmet support needs
- "Camouflaging" of autism spectrum conditions.

"Camouflaging" refers to attempts to conceal autism spectrum conditions in order to fit in to social situations and is associated with suicidal behaviours even when no mental health difficulties have been identified (Cassidy et al, 2018).

People with autism spectrum conditions have an increased likelihood of experiencing the risk factors for suicidality outlined above (Pelton and Cassidy, 2017) compared with the general population. People with autism spectrum conditions also find developing coping strategies to deal with these and other life stressors more challenging due to difficulties in imagination and in thinking flexibly (Segers and Rawana, 2014).

People with autism spectrum conditions who attempted suicide (Kato et al, 2013):

- Had persistent rather than spontaneous stressors,
- Used more lethal means, and
- Were less connected to psychiatric services than people who attempted suicide but did not have autism spectrum conditions.

This increased risk of suicide is also present in people who show symptoms of, but do not have diagnosed autism spectrum conditions (Richards et al, 2019). No diagnostic assessment for risk of suicide has yet been validated on people with autism spectrum conditions (Cassidy, 2018b).

APPENDIX 10: Trauma Informed Practice

The Blue Knot Foundation has produced guidance and resources on trauma informed practice https://blueknot.org.au/resources/blue-knot-publications/guidelines/. This guidance has been adapted for the Trauma-Informed Toolkit published by the Scottish Government https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/pages/12/#AP2 , some of which is listed below:

1) Understand the impacts of stress on the brain

- Under stress, we can all lose the ability to be calm, reflect and respond flexibly.

2) Signs of trauma can take different forms

- Trauma responses include both:
- Hy**per**arousal (obvious agitation, e.g. shaking, sweating, raised voice)
- and
- Hy**po**arousal (e.g., glazed eyes; `zoning out'; `shut down'; can be harder to detect).

3) Simple ways to lower arousal can restore safety

- We can all learn to do this for ourselves and others.
- Lowering arousal allows the person to return to a place where they can tolerate their feelings (`the window of tolerance') and avoid being overwhelmed from hyper- and hypoarousal.

4) Challenging responses and behaviours can be defences against stress

- Traumatised people develop coping strategies to protect them from being overwhelmed.
- Understanding this allows us to consider what may have `happened to' a person rather than what is `wrong' with a person.

5) The `way in which' we interact with a traumatised person (not just `what' we say and do) is important

- It can also either increase or decrease a person's stress levels. This underlines the importance of knowing how to interact in a trauma-informed way, not make things worse, and `do no harm'.

***6)* Understanding the stress response**

Hyp*er*arousal

- Increased heart rate
- Increased rate of breathing
- Blood flows from the arms and legs to organs and major muscle groups
- Tension in the person's muscles
- Hypervigilance i.e., being on guard (for threat)
- Problems with the digestive system
- Disturbance of sleep and energy levels

Hy*po*arousal

- Having feelings of being 'shut down' or 'cut off'
- Avoidant – avoiding places, events, feelings
- Withdrawn
- Loss of humour, motivation, pleasure and connection with others
- Disturbance of sleep and energy levels

***7)* Tips to reduce stress**

Hyp*er*arousal

- Recognise being hyper-aroused is a distress/fear response
- Validate their response ('I can see you are...')
- Support the person to feel safe
- Turn the person's focus to their current need/task
- Support gentle ways for the person to release some energy
- Help the person to feel grounded, and feel settled in their body (e.g. feet firmly on the floor; some stretches)

Hy*po*arousal

- Recognise being hypo-aroused is a distress/fear response.
- Support the person to feel safe.
- Provide an opportunity for the person to express their current needs without pressuring them to do so.
- Pay attention to the physical space (more or less proximity to others?).
- Help the person to become aware of their current surroundings and to tune into their senses.
- Encourage the person to move a little, change their posture/position or practice a familiar ritual or rhythm. Emphasis should be on movement rather than sensations for hypo-aroused states.
- Direct attention outward (e.g., noticing objects in the room) rather than inward.

APPENDIX 5: Literature review

The literature review was conducted in November-December 2020 using the following resources:

1. An internet search using Google to find open access journals and articles
2. The Royal Society of Medicine's on-line journals and related sources
3. The British Psychological Society's on-line journals and related sources
4. The Athens on-line journals and related sources