Safeguarding Adults Review

commissioned by the Oxfordshire Safeguarding Adults Board

24 January 2022

Key Issues: Self-neglect, Substance Misuse, Self-harm, Homelessness

Key considerations: *principle-led safeguarding, multi-agency coordination and risk management, whole family approach, mental capacity, psychological approach, eviction, coronavirus*

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Executive Summary

Ian died in April 2020 at just 36 years of age. The Coroner was satisfied that his death was due to natural causes. Prior to his death, Ian had been in receipt of multiple health, social and homelessness services in regard to his mental health, addiction and self-neglect issues. The day after Ian was evicted from his supported housing onto the street, he had a heart attack and collapsed; he never regained consciousness and died three weeks later. This was during the first national lockdown caused by the 'covid-19' pandemic. In May 2020, the Oxfordshire Safeguarding Adults Board (OSAB) decided to conduct a Safeguarding Adult Review (SAR) to explore how agencies had worked together to safeguard Ian and to learn lessons for the future.

This SAR was initiated just as a thematic SAR was being concluded regarding the premature deaths of homeless people in Oxfordshire in 2018/19, and in the context of a dramatic rise in deaths of homeless people nationally. On reviewing Ian's story, OSAB considered that many of the issues identified in the thematic SAR would be relevant. The authors were asked to clarify the key issues for Ian, and to draw out any different or additional issues, focussing on the final 17 months of his life.

Using a systemic approach, the report describes and reflects on the actions of agencies and practitioners, trying to understand what made those actions the best the person could manage at that time (the person could be the professional, the family or Ian himself). Where the authors perceived a gap between the strategic level (eg. frameworks and policies) and the operational level (what practitioners do day-to-day), the authors explored why that might be. They also considered: if someone in a similar situation to Ian were to seek services, what would be different now?

The authors identified and analysed 8 key issues:

i. **Multi-agency care coordination and risk management**: though in receipt of services from nine different organisations, and despite increasing concern for Ian's safety and wellbeing, he had no comprehensive support plan, or risk assessment and management plan. Ian was never referred for a social care assessment and a safeguarding referral for him around 6 months before he died was not acted upon. There is no evidence that he was ever discussed at any of the multi-agency forums that take place under the 'Homeless Pathway'.

ii. **A whole family approach**: Ian's parents were heavily involved in supporting him but were never offered carers assessments for their own support. Ian maintained frequent contact with his daughters even when homeless and described how much those relationships meant

to him. His ex-partner and children were known to the local authority Children's Services. Domestic abuse issues were also on record. But the authors found no evidence of a co-ordinated 'whole family' response to a family clearly facing multiple problems and needs.

iii. **Mental Capacity**: It was clear that not all agencies understood that there is an expectation placed upon them to assess mental capacity. Outside of mental health and hospital services, the authors encountered many practitioners who did not see it as their role to assess capacity nor as something their organisation expected them to do, even when asking a person to give consent, provide a signature, make a decision, or agree with a suggested course of action important to the person's care. The authors also found no sign of any consideration of executive capacity (the ability to act on intentions and carry out plans), although it is known that prolonged alcohol and drug abuse can affect this (as also can trauma, and minor neurological damage from brain injury due to fights or accidents). The authors wonder how expecting a client to take the initiative to contact a service, or to self-refer, fits with impaired executive capacity?

iv. **Self-neglect, trauma and frequent attendance at the hospital Emergency Department:** Towards the end of his life, Ian showed extreme self-neglect, unable to manage the most basic self-care (nutrition, hygiene etc). It is not always possible to establish a root cause for self-neglecting behaviours and there are numerous possible influences, including addictions, brain injury and traumatic life events. The experience of seeking help that is not forthcoming can compound past trauma, adding to a person's sense of rejection, loss, fear and anxiety. Ian was a frequent attender at the ED, even though there was often no medical need for him to be there. But where else could he go? The authors are concerned about the limited options available to the ambulance service (or anyone else) for a place to take Ian when he was in crisis.

v. **A psychological approach:** Ian was known to have an alcohol problem by his early 20s (possibly earlier) and also abused various illegal drugs for over ten years. In his final year and a half, Ian harmed himself through extreme self-neglect and attempted suicide several times. Ian accessed substance misuse treatment for just a few months, and only in the last year of his life. His GP and others (including some family members) connected his alcohol use to anxiety. Ian was advised by mental health services to seek treatment for anxiety once he was abstinent from alcohol and drugs. The report explores the resulting dilemma: giving up his usual coping mechanism before he had found another way to cope - and to do this while homeless, jobless etc made it even more challenging. What more could be done to support people like Ian to move between separate mental health and substance misuse services? And whose professional role is it to take the time to build a relationship of trust with Ian, to seek to understand his anxiety and the underlying causes of his self-neglect, and support him to overcome his difficulties?

vi. **The eviction:** The report closely examines events leading up to Ian's eviction from supported housing. Opportunities to prevent Ian's homelessness were not used to the full and the report explores why that might have been, concluding that housing providers need reassurance that in accommodating complex and challenging individuals, they will not be left

alone to manage a crisis. Equally, Commissioners need reassurance that housing providers will use all available channels and multi-agency forums to seek support when crises occur, and indeed to prevent them. In the Terms of Reference, the authors were specifically directed to examine the role of Commissioners in the eviction, and in doing so, were impressed that in this critical week (of the pandemic), their communication remained so clear, responsive and solution-focussed. While the eviction appears legally permissible (because Ian had signed an Excluded Licence Agreement rather than a tenancy agreement), the authors feel that the eviction clause leaves licensees in a very vulnerable position, and should be reviewed. This section also reviews mental capacity issues with respect to eviction and recommends supported housing providers always to document how they considered mental capacity when signing a licence or tenancy agreement with a new client.

vii. **Coronavirus**: The report notes the context in which decisions were taken by agencies about Ian in the final few weeks of his life: the emerging 'covid-19' pandemic. By March 2020, pressure was building on public services at all levels, and decision-making happened in the context of high uncertainty and huge apprehension about what was coming. Oxford's "Everyone-In" initiative to provide self-contained accommodation for all homeless people was impressive, and would have increased Ian's (short-term) housing options, had he not collapsed and been hospitalised.

viii. **Wellbeing and Safeguarding Principles**: Finally, the report comments on the persistence of the idea that safeguarding a person means referring them to a specific safeguarding team at the local authority, rather than working with a client, and collaboratively with other agencies, to understand: what does 'safe' look like for you? What does 'well' look like for you?' The authors describe this as a 'process-led approach" rather than the 'principle-led' approach introduced by the Care Act 2014. Some ideas about how safeguarding principles could have been applied more widely are given in an appendix.

Conclusion

This review puts forward 19 recommendations to help prevent future deaths or serious harm. Overall, the review recommends better coordination of care and support, addressing the needs of the whole family, with clear identification of who leads cases and what is expected of each contributing agency. Where there are safeguarding concerns, oversight and guidance to the response by agencies must be provided by the local authority. There needs to be greater integration of mental health, substance misuse and homeless services, with at least one agency having the resources and responsibility to try to find out what has happened to a person that leads them to neglect themselves so seriously, and to formulate robust care and risk management plans. The Care Act (2014) and Mental Capacity Act (2005) provide the framework for effective care coordination but these Acts are not widely understood at the operational level and there is a system-wide issue of Care Act compliance.

The authors provide 35 resources and numerous links to other information that they hope will aid OSAB and practitioners in its partner agencies and commissioned services to develop their practice and create local solutions to the problems described in this report.

Summary of Recommendations

The review took over a year to complete, due in large part to the pressures on agencies from the ongoing 'covid-19' pandemic. During this year, an action plan was implemented following the earlier thematic review of the deaths of homeless people in 2018/19. Six of the recommendations from this review appear to be additional to the issues identified in the thematic review. The remainder have been expressed below as reflective questions for quality assurance of the thematic review action plan.

New Learning

Based on the authors' understanding of the thematic review and resulting action plan, they suggest that the following issues have not previously been highlighted, and these recommendations should be prioritised by the Board.

1. The Local Authority oversees a review of procedures to ensure that it retains oversight of safeguarding and vulnerable adult concerns passed to the mental health trust.
2. OSAB to seek assurance from members that they are promoting the use of carers assessments and support for carers of people with addiction issues and complex mental health needs.
3. OSAB partners to consider where the ambulance service can take a person who does not need further medical attention but who is highly distressed and under the influence of alcohol or illicit drugs. It is acknowledged that there may be no 'easy fix' for this issue but it must sit on the risk register of the appropriate strategic partnership.
4. Agencies to be held accountable for the support they offer to agencies in the homeless pathway to manage homeless people with complex care and support needs.
5. OSAB to escalate to the Health and Wellbeing Board the need to make mental health support more accessible for people who misuse alcohol or illicit drugs, enabling them to have treatment plans that address both their addiction and their mental ill-health in a connected and holistic manner.
6. The use of 'excluded licence agreements' in supported housing should be reviewed, with a view to providing some security to residents, and clearer information about breaches.
7. The supportive learning points below to be used in the quality assurance audit undertaken by PIQA[1] into the effectiveness of actions taken in the homeless thematic review.
8. OSAB partners to cascade the report and its findings within their organisations and networks to promote the learning of the lessons from this case.

Supportive Learning

The learning points below directly relate to findings within the thematic review concluded in 2020 and so they have been rephrased in the form of reflective questions for quality-assuring the action

[1] PIQA – the Performance Information Quality Assurance Subgroup of the Oxfordshire Safeguarding Adults Board

plan that followed that review. References to 'OSAB and partners' include services commissioned by OSAB partners from the third sector.

1. Has the OSAB done all it can to ensure action is taken by its partners to create greater awareness amongst their staff at all levels, of the role of the local authority in conducting social care assessments and protecting homeless people with complex needs at high risk of harm from self-neglect and addictions?
2. Has the OSAB done all it can to ensure staff across the partnership understand where to send safeguarding referrals for people who they believe to have mental health issues (whether or not the person is open to mental health services)? Further, is there a need to raise awareness that concerns sent to the Local Authority may be dealt with by the Local Authority Safeguarding Team, a L.A. Locality Team, or by Social Workers in Oxford Health NHS Foundation Trust if the person is open to mental health services?
3. Is OSAB reassured that there is sufficient capacity across the partnership to provide social care assessments and care coordination to homeless people with complex care and support needs, such that front-line practitioners do not feel inhibited from referring all appropriate clients?
4. Has the OSAB done all it can to ensure that partners have a robust local approach to working with whole families with multiple problems and needs, working jointly with the Oxfordshire Safeguarding Children's Board? This to include improved understanding of what and how to record information about clients' contact with their non-resident children.
5. Have the outcomes/achievements of the High Intensity User project been considered by the OSAB and its partners? When doing so, did the project 'just' divert distress from the ED (a valuable outcome given the pressure on EDs) or also reduce distress by encouraging new options and new ways of working for people who were attending frequently?
6. Has the OSAB and its partners done all they can to raise awareness of EDT (the Local Authority Emergency Duty Team) and its role?
7. Has the OSAB and its partners done all they can to ensure member agencies' work with clients fully reflects the Care Act's wellbeing and safeguarding principles? Practitioners should be able to say: this is how we promoted X's wellbeing; this is how we empowered X; this is how we prevented harm; this is why our response was proportionate; this is how we worked in partnership; this is how we held ourselves and others accountable; etc

Mental Capacity reflective questions

8. Is OSAB reassured that all partners understand their responsibilities under the Mental Capacity Act, and know when and how to assess mental capacity (including executive capacity)?
9. Is OSAB reassured that there has been system-wide consideration of executive capacity and how services can incorporate this understanding into the way they work with adults whose self-neglect is related to addictions and trauma? Are any additional processes required to encourage engagement of these clients with services?

Acknowledgments

The authors would like to thank Ian's family for explaining their thoughts and feelings about Ian's and their own experiences with agencies. During a very difficult period of time (the SARS-CoV-2 pandemic) agencies talked with the authors and were open and transparent about their journey in supporting Ian. The authors would like to thank all concerned for their participation in this review.