Safeguarding Adults Thematic Review

Self-neglect, fire safety and alcohol dependency

Overview Report

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1. Introduction

1.1 MKTSP commissioned this review following the death of two adults in separate unconnected incidents. For the purposes of anonymity, they are known within this review as 'Charles' and 'Dylan'. Both men were white British. Charles was in his early 70s whilst Dylan was in his early 50s. Both had experienced alcohol abuse for many years. Both adults were known to services, and it was understood they could be at risk of harm from poor management of their health, personal care and long-standing alcohol abuse. They both lived alone, though did have family members who were seen by practitioners as 'protective factors'.

1.2 Following notification of the circumstances of Charles and Dylan's deaths, MK Together's Case Review Panel were satisfied that in both cases there was evidence of multiple agencies making persistent offers of support to reduce risk, such that for Dylan this meant his case would be a discretionary review. However, given the numerous fire risks factors were known in Charles' case (such that this case would meet the mandatory SAR criteria) and a lack of coordinated, multi-agency risk mitigation in both cases, the panel concluded there are lessons to be learned about the way in which local practitioners and agencies work together to identify foreseeable harm and prevent harms associated with self-neglect.

1.3 The panel were also mindful of the completion in 2021 of two SAR reports[1] and subsequent work by the partnership to develop a framework for assessing risk, initiating multi-agency responses by any of the safeguarding partners and clear guidance within its website on the interagency responsibilities to respond to self-neglect.[2] The panel therefore recommended a thematic review to understand how to better support MK Together partners keep safe adults at high risk where self-neglect and alcohol abuse is a factor.

1.4 The reviewers wish to express their sincere condolences to members of Charles and Dylan's family for their loss. The reviewers are also grateful to the professionals who worked with both men for sharing their insights so honestly. The efforts they made to support them and try to keep them safe were apparent.

2. Scope of Review

Purpose of a Safeguarding Adult Review

2.1. Prior to the commissioning of this review, the circumstances surrounding Charles' death had been subject to an internal serious incident review by Buckingham Fire and Rescue Service and an inquest. These concluded he died in an accidental fire, likely started when a cigarette ignited his bedding and accelerated by lighter fuel[3] and alcohol on his bed. There was no inquest into Dylan's death as it was determined that he died of natural causes.

2.2. This review is not intended to duplicate Coronial processes, re-investigate causes of death or apportion blame. This review will examine the effectiveness of safeguarding procedures (both multi-agency and individual organisations) to inform and improve local interagency practice. MK Together's Case Review Panel recognised that, prior to the time periods explored in this review, multi-agency safeguarding policies had been reworked to provide practical assistance for practitioners working with adults experiencing alcohol dependency and at risk of self-neglect. Therefore, as part of their statutory duties, namely, to assist member organisations to apply

[1] "Denise' and a Thematic review into three adults who died and were known to exhibit self-neglecting behaviours. These are available on request at mktogether@milton-keynes.gov.uk

[2] Available at: https://www.mktogether.co.uk/sites/default/files/2022-10/Self-Neglect%20and%20Hoarding%20Guidance.pdf

[3] He was using a zippo lighter and fuel that had an additive to ensure it ignited fast and was more flammable. Fire officers involved in this review highlighted safer alternatives are available if the adult is unwilling to accept smoking cassation support.

lessons to future cases,[4] MK Together wished to explore barriers and enablers to multi-agency responses via a 'whole system' approach.

2.3. Within such a review there is a strong focus on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Charles and Dylan from harm. The learning produced addresses 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.

Methodology

2.4. MKTSP commissioned the independent reviewer to conduct this SAR using the Social Care Institute for Excellence Learning Together methodology with tools from the SCIE SAR in Rapid Time methodology. The following agencies provided documentation to support the review:

- Central and North West London ['CNWL'] NHS Trust's Substance misuse service and District nursing services
- South Central Ambulance Service ['SCAS']
- Milton Keynes Adult Social Care
- Both Charles and Dylan's GPs
- Charles' domiciliary care provider
- Bucks Fire and Rescue Service ['BFRS']
- Bedfordshire, Luton and Milton Keynes Integrated Care Board ['BLMK ICB']
- Thames Valley Police ['TVP']

2.5. Multi-agency learning events took place, both with front-line practitioners who worked with Charles and Dylan, and the leaders who oversaw the services involved in supporting them. This report draws on national guidance and research, policies and guidance available on the MK Together site, documents provided by partners for the review and discussions with frontline practitioners, managerial and senior leaders from across relevant partner agencies.

Involvement of Charles and Dylan's families

2.6. It is good practice to invite family members to participate in reviews as they have a unique perspective on the adult's experience. They can also provide a more holistic understanding of the person who has died or suffered harm. However, those important benefits to any review must also be weighed against any adverse impact such a request may have on family members. Occasionally there are compelling reasons why a decision might be made not to invite family members to contribute. Equally, family members may feel unable to do so.

2.7. Whilst Charles' family were invited to take part, to date they have not responded so may not feel able to do so. The reviewers and MK Together partners remain committed to supporting his family's involvement and invited their comments on this report before publication.

2.8. Dylan had past convictions for domestic abuse. Professionals reported that his partner continued to experience this during the review period but also would contact professionals to seek assistance for him. This is commendable, however, given her experiences and the young age of his children the reviewers and MK partners agreed it could be detrimental to their wellbeing to seek their involvement. We have endeavoured to record both Charles and Dylan's experiences in their own voices, taking these from case notes.

[4] Care Act 2014, 44(5)

Themes

2.9. The period under review for Charles was from April 2019 until his death in March 2022 and for Dylan from November 2020 until his death in July 2022. MK Together Partnership has prioritised the following themes for illumination through the review:

- Do agencies use multi-agency forums to share information and coordinate responses where there are persistent concerns regarding self-neglect (including substance misuse and fire safety risks), even if there is no obvious crisis?
- is communication effective, and do agencies use existing policies and procedures, including under s42 and MK Together's decision tool,[5] where routine care planning interventions have not removed or reduced the risks?
- Where adults are at higher risk of a fatal fire or overdose, and are not compliant with preventative interventions to reduce risk, is their capacity to keep themselves safe routinely assessed; do partner agencies have systems in place to monitor the quality of those assessments and decision-making following completion of capacity assessments?
- given the importance placed on prevention and de-escalation of needs within strategic plans and legislation, how can we support frontline staff when they are working with adults with care and support needs who misuse substances and are at risk of abuse (including self-neglect and suicide); are services flexible to make reasonable adjustments when alcohol/drug use is a factor or are services/ specialisms resulting in barriers to effective interventions?
- How do partner agencies disseminate new safeguarding policies or good practice guidance; are the processes for monitoring practice improvement robust; what more might be needed by MK Together and partner agencies to ensure sustainable practice improvement?

3. Narrative Chronology

A common finding in safeguarding adults reviews involving self-neglect and/or alcohol dependency is that those responsible for assessing and addressing the adult's needs or safeguarding risks work without a full understanding of the whole picture, including wider legal duties owed by partners. This section reports on how agencies recognised and responded to concerns as they unfolded. We have grouped these according to how they presented to different agencies to draw attention to the actions taken to overcome 'silo' work practices.

Charles

3.1. Practitioners who worked with Charles spoke of a lonely, very physically dependent man, but one who knew his own mind and was very determined to retain some control over his life. He described himself within one social care assessment as a '*cantankerous old man*'.[6] He had been diagnosed with polio as a child. From 2013 he was unable to use his right arm or hand and had limited use of his left arm and hand following a serious car accident (for which he was imprisoned). In April 2019, on his release from prison, he was unable to stand for long periods of time due to osteoporosis in his hips and spine and experienced pain in both legs.

3.2. Charles was known to smoke and drink heavily. He had been diagnosed with COPD and liver damage due to excessive alcohol intake.

3.3. Throughout the review period, he received domiciliary care to support him daily with personal hygiene, food preparation, administering medication and topical emollient creams. In July 2019 he suffered a significant fall and was admitted to hospital where he was assessed as having full capacity. Hospital staff spoke to him '*regarding support to change smoking and drinking habits.*

[5] Available at: https://www.mktogether.co.uk/sites/default/files/2022-10/Decision%20Making%20Tool.pdf
[6] Taken from MKBC's ASC IMR report

Declined support. Stated alcohol and smoking were the only two things left and won't be giving them up.'[7] He was discharged from hospital in September 2019 and from this time was bed-bound.

3.4. Professionals reported that he regularly declined interventions aimed at reducing recognised risks to his health and his safety. They also reported there was no indication that, despite often being low in mood, he lacked capacity to understand the risks associated with drinking and smoking in bed or declining medical and social care.

3.5. During the review period there was evidence of persistent offers to reduce risk, including:

- The care agency reported he frequently declined support to properly meet his needs. For example, they tried to arrange for physiotherapy, the FALLS team, district nurse, his GP and occupational therapy to assess him but he declined those interventions.
- In October 2019 his GP offered to refer him for alcohol support services but he declined.
- In May 2020 South Central Ambulance Service staff attended his home as he had reported shortness of breath for two weeks. He declined to attend hospital or the GP's offer to prescribe antibiotics. At that time, he also declined to allow a care line to be fitted and was noted to have capacity.
- He instructed his carer to notify his GP that he wished for a 'DNACPR' notification on his health record.
- In January 2021 he declined consent for CNWL's district nursing to treat him or for the carers to change his bed despite having been informed by the attending RGN from the district nursing service of the infection risks.
- In August 2021, the review team manager advised the social work assistant undertaking his review to explore self-neglect, particularly fire risk. During this review of his social care needs he '*was adamant that he didn't want to give up smoking and drinking and stated that he is a person 'who likes things being done his way.. He refuses to have community alarm, even though it would be beneficial*.' He also declined a referral for occupational therapy and talking therapies regarding his mental health as he felt they were unlikely to work.
- It was also understood that he owned his own home and had declined to allow for smoke alarms to be fitted.

3.6. There was also evidence that the care agency and MK Together member agencies recognised and reported to the local authority their safeguarding concerns in line with their organisation's safeguarding policy. In addition, we have listed examples of multi-agency discussions to seek to resolve safety concerns. These included:

- In October 2019 the care agency raised a safeguarding concern to the local authority.
- November, a thorough MDT assessment was completed with CNWL's RGN, carers and staff nurse,[8] he declined advice and support to reduce risks of pressure ulcers, declined smoking cessation referral and was informed that a safeguarding referral would be made due to the risks of self-neglect. A capacity assessment was completed in respect of his understanding of wound care and refusal to upgrade his mattress. His GP was notified of the assessment and safeguarding concerns. The district nursing service also updated records to advise all visits should be between 10.30-11.30 so that the carer was present and could encourage him to accept support. This was very good practice and in line with local policy and national practice standards. In response to the safeguarding referral CNWL were advised by adult social care that although he *'has care and support needs, he does have capacity to make decisions in relation to his day to day needs and has stated he does not want support*…[the provider] *have a support plan and risk assessments in place. Screened as a safeguarding alert with no identified role for safeguarding.'*

[7] Taken from the combined chronology collated for this review

[8] The assessment included Malnutrition Universal Screening Tool risk assessment (MUST), assess skin assessment and skin care, surface keep moving, incontinence, nutrition and hydration (aSSKIN) risk assessment, Vital observations taken and flagged 89% oxygen levels. His GP was notified of the outcome and a Datix submitted (CNWL135599 and FS377948080).

- In early 2020 his GP records indicate that a multi-agency meeting took place in response to safeguarding concerns. CNWL's district nurses summitted another safeguarding referral.[9]
- In March 2021 a safeguarding case conference advised the care agency to conduct a 'environmental and home risk assessment'[10] and concluded 'home first involvement due to self-neglect'.[11]
- His GP records report a safeguarding plan was completed on the 21.06.21.
- In July 2021 he was coughing blood. SCAS staff submitted a safeguarding referral. He was conveyed to Northampton General Hospital concerned that the house was '*very untidy, and limited egress. Exposed electrical wires noted with no RCD*."[12] This information was subsequently shared with his brother who cleared sufficient space to ensure that it would be possible to use alternative exits if there was a fire.
- In November 2021 the carers reported concerns regarding his skin integrity to CNWL's district nursing's single point of access ['SPA']. Whilst he initially declined support, there is evidence of multi-agency planning and compassionate, professional persistence so that nurses were able to provide advice and some treatment, thereby reducing the risk.
- In early February 2022 his carers requested advice from adult social care (older people team). They were advised to raise this with his GP who, in turn, contacted SCAS over concerns he was declining food and drink. Later that month, his carer, GP and SCAS raised further concerns regarding a deterioration in his health and SCAS completed a paramedic review, but at his request, took no further action. He died in early March 2022.

Dylan

3.7. Practitioners supporting Dylan during the review period knew very little about his early life. It was understood he had a conviction in 1984 and had been a successful businessman, but started drinking heavily after the financial crash in 2008. This impacted on his physical health, with numerous hospital admissions and frequent contact with ambulance. By September 2020 he had diagnosed heart condition and was suffering seizures and cirrhosis of the liver. He was awaiting a liver transplant. He was also noted to suffer with anxiety.

3.8. Dylan experienced periods of homelessness both before and throughout the review period. There is evidence of significant and persistent assistance offered to him by the Council's housing department who responded in a timely and person-centred way each time he risked street homelessness. This included:

- In 2020 he was accommodated on release from prison by the Council, but was evicted from temporary hotel accommodation for drinking on the premises in November 2020. At this time, he was in hospital and the hotel manager was also notified he had been recalled to prison. The hotel manager notified relevant agencies that he was in hospital.
- Following his discharge from hospital, he was again accommodated by the Council[13] in temporary hotel accommodation but by May 2021 he was facing eviction for antisocial behaviour. He was identified as someone who may benefit from support through the 'Housing First' panel[14] who agreed to find alternative temporary hotel accommodation whilst a social care assessment was ongoing and to refer him to the supported living accommodation panel as '*he did have ill health and physical needs*'.[15] The outcome of the social care assessment (that he did not have social care needs) was communicated to the housing's Homeless prevention team in mid-June.

[9] Taken from the combined chronology submitted for this review, referral ref: FS393289515
[10] Taken from BFRS chronology completed for this review, reference (Id. No. 14306351)
[11] Taken from the GP's chronology prepared for the purposes of this review.
[12] Taken from the combined chronology submitted for this review
[13] In line with their duties under the Housing Act 1996 (as amended by the Homelessness Reduction Act)
[14] This pathway brings together staff with expertise form across the Council's housing, social care, neighbourhood teams, antisocial behaviour teams, social prescribers, mental health and supported housing navigators, substance misuse, criminal justice liaison practitioners, probation and TVP's street activity policing team. They are also able to refer adults within their cohort for additional tenancy support to 'Connection Support' officers.
[15] Taken from the combined chronology completed for this review.

- In late June 2021, he was put forward by the Council's housing department for a supported living placement and it was agreed that, if he were accepted, a re-assessment of his care needs would be required.
- He was referred for support to Connection Support and allocated a worker. It was noted that he should be jointly visited, but very little information regarding his level of need and past offending history was shared. It appears from case notes and discussions at the practitioner event that, thereafter, agencies believed the Connections Support worker would provide a coordinating role in supporting him to address his mental and physical ill health. She was frequently his point of contact when he felt in crisis. Case records demonstrate she made numerous attempts to contact him, escalating her concerns for his welfare to police or ambulance services when she was unable to make contact and had reasonable concerns about his safety.
- In April 2022 Dylan was notified he may be permanently rehoused in a new build. He failed to complete the paperwork for this however, so the offer was withdrawn in May 2022.

3.9. Both before and during the period under review, Dylan was known to criminal justice agencies as a perpetrator of domestic abuse.[16] Case records and discussions during the review demonstrated proactive attempts by his probation officer to liaise with agencies in order to better manage this risk. These included:

- Prior to the period under review, he had received a custodial sentence for breach of bail conditions and criminal damage following a domestic abuse incident and been made subject to a restraining order which was due to remain in force until December 2022. This prevented any contact with his wife, save through her solicitor or his brother and only then in respect of arrangements for contact with his children.
- He was released from prison under license and accommodated by the local authority, but by November 2020 agencies reported he was showing sexualised behaviours, was inappropriately dressed in public areas, was making inappropriate frequent calls to 999 and was severely neglecting his environment and self-care. Following two missed appointments with probation, his probation officer recalled him to prison concerned that his reoffending risk could not be managed in the community given the absence of any evidence that he would comply with his license conditions; his heavy drinking had resulted in notice of possible eviction from temporary accommodation.
- In January 2021 he was charged with three offences of breaching the restraining order and was sentenced to a community order with an alcohol treatment requirement under the supervision of probation for nine months. This required that he comply with instructions to attend appointments, and to participate in any activity as required up to a maximum of ten days. He was referred to ARC-MK, Addictions Recovery Community ['ARC'] run by CNWL and met with ARC's team leader and his probation officer in February 2021.
- His probation officer also recognised the lack of a daily structure or social network increased his likelihood of reoffending so arranged for him to receive support from a mentor from the 'New Leaf' service.
- He subsequently breached the restraining order again in March but police delays completing relevant paperwork for the CPS meant this was not actioned by December 2021. Enquires were then made to ascertain if witnesses would support the investigation and, because one of the witnesses couldn't be traced and because there had been no further breaches, police recommended no further action.

3.10. During the review period complaints were made by his neighbours regarding antisocial behaviours. Dylan also made counter-allegations against a specific tenant. There is evidence within the case notes that police and housing officers responded appropriately to the threats of violence and spoke with both tenants' support workers to notify them of concerns. For example, in May 2022 he contacted the police to report criminal damage and threats from his neighbour. The police spoke with the neighbour and filed the report for 'no further action' as Dylan had

[16] Namely, threatening, coercive behaviours and physical violence- against his wife and her nephew.

requested this, but wanted it logged. The police officer agreed to share the information with the neighbourhood police team. There is also evidence that the police contacted his connection support worker to update her on the steps taken and confirmed Dylan's neighbour was in receipt of social care support and would be moving from the property soon. Dylan subsequently confirmed his neighbour had moved on at the beginning of April.

3.11. Throughout the period he also received support to address his alcohol use. Dylan was not physically dependent on alcohol. He did not exhibit physical withdrawal symptoms when not drinking. However, practitioners who knew him well felt this was his coping mechanism so queried if he had a psychological dependency. He described himself as a 'binge drinker' but this presented as very extreme. For example, throughout the review period there were periods when Dylan would drink to such excess that he was immobile, doubly incontinent, and unable to retain food. These periods often lasted for weeks. He also had long periods of abstinence and showed a desire to engage and remain sober, though his ability to do so was not consistent. For example:

- In November 2020, following an alcohol related fall, was admitted to hospital where he received medically assisted detoxification. Specialist staff within the hospital[17] completed an assessment and appropriately referred him to CNWL's community-based substance misuse services- ARC. ARC only received the referral the day after Dylan had been discharged from the hospital so were unable to follow this up.
- Following his conviction for further domestic abuse offences and the imposition of an alcohol treatment order, he was allocated an ARC working in March 2021. From this time until his death in July 2022, he had approximately 46 contacts with ARC. They reported during this period, the recently commissioned service primarily contacted Dylan by phone and text messages because of Covid Restrictions in force at the time. They felt he responded proactively to this contact between April 2021- March 2022 though his participation was predominantly through virtual groupwork sessions, meaning the exact level of his alcohol consumption was not known.
- During that winter he frequently came to the attention of SCAS and police over concerns regarding his drinking. As set out below these were responded to in line with their duty of care and there is evidence of referrals made (in line with local safeguarding policies) to the Council. It is evident, however, from discussions with practitioners and the case records that ARC remained unaware he was drinking heavily during some periods when he was still subject to the alcohol treatment order, nor were they aware that his needs (and corresponding risks) had escalated during those periods.
- In February 2022 he reported to his connection support worker he was '*feeling back on track and positive about life*' and with CNWL's groupwork intervention where he presented *'very well with a clean shave and haircut. He informed the group that he'd had a good week in which he went out with his sons for lunch and spoilt them (as well as himself) at Sports Direct*.' The following week he reported he had stayed sober for 3 weeks and spoken to his sons every night which 'boosted his confidence.' He appeared, thereafter, to have a stable period of sobriety and engagement with the group work.
- However, in June 2022 he reported to SCAS he had been drinking and was reportedly clearly upset but was heavily intoxicated and abusive to staff when they tried to assist him.

3.12. Dylan relied heavily on emergency services (usually by calling 999) to support him when he was drinking. He made several calls to the police whilst seemingly intoxicated reporting threats to kill, theft or assaults against him. In February 2021 he reported to the police he had been verbally abused outside the hotel. It was reported in the case notes that he had been drinking heavily and could not identify the person. He declined to provide any more details to the police. During April 2021 he also made a further report to the police of threats to kill by an associate whilst intoxicated, but later withdrew the allegation. He made 5 further allegations during the

[17] CNWL hospital liaison nurse working within MKUHT referred Dylan to the Alcohol Recovery Centre ['ARC'] run by CNWL in Milton Keynes.

review period.[18] The case records demonstrate police attempted to follow up each allegation proportionately and in line with their duty of care, but Dylan either did not respond, withdrew his allegations, or could not provide evidence of events complained about. Follow up investigations included attempts by police to verify Dylan's account with hotel staff. They also evidence consideration of their duties to safeguard Dylan, by conducting enquiries to rule out risks of cuckooing or intimidation and completing return visits to check on his welfare. There was also evidence that officers made contact with the Council's adult social care department to ensure he had support, and his needs were being addressed. This was good practice.

3.13. He also frequently sought emergency medical attention. This included:

- In March 2021 Dylan was supported by SCAS after a fall and altercation with a group of children who alleged he had been inappropriate. He initially declined to go to hospital but was subsequently taken and discharged. At 2am that night SCAS attended his hotel (alongside the police) as he had become agitated after asking for assistance with his mental health. He was deemed intoxicated and without capacity. Police aided SCAS to convey him to hospital under powers conferred by the Mental Capacity Act 2005.
- In August 2021 SCAS attended following a 999 call as Dylan was suffering a rapid heartbeat and had chest pain. He became aggressive and declined hospital as soon as it was mentioned. He declined further treatment and assessment, the crew explained he may deteriorate and become very unwell but assessed that he had capacity to decline treatment so provided advice if his condition worsened. In October 2021 SCAS attended after a 999 call as he could not breathe. Clinical observations were normal. Crew noted he was intoxicated and suffering anxiety. He called 999 again two days later as he was depressed. He was, by now, identified as a 'high intensity user' as he had over 16 ambulance callouts. The crew noted he was 'much calmer before leaving', they signposted to Samaritans and asked him to follow up with his GP.
- Over Oct-Nov 2021 Dylan called 999 again frequently[19] complaining of shortness of breath, each time his clinical observations were normal. Case records evidence consideration of any safeguarding risk e.g. on the 28.10.21 the crew report '*mild self-neglect but fridge well stocked with food*.' He was often discharged at the scene, was offered advice (e.g. to self-refer to ARC or speak with his GP), or occasionally conveyed to hospital.
- He was admitted to hospital on 01.02.22 following an overdose, but self-discharged before seeing a doctor. The hospital notified his GP. He disclosed suicidal ideation to his connection worker and asked she call an ambulance. He subsequently called 999 complaining of chest pains. He was noted to be heavily intoxicated, non-compliant with his medication resulting in overdoses.
- In May 2022 he called 999 as had shortness of breath and crew noticed he had cellulitis in both legs. He declined hospital admission and denied alcohol use. He called 999 again on the following week with abdominal pain. He initially declined to attend A&E or further assessment but was admitted subsequently with cellulitis across his abdomen and legs.
- In June he called 999 frequently over the course of two days.[20]

3.14. There was evidence that practitioners recognised safeguarding risks associated with self-neglect and alcohol misuse and, in accordance with their safeguarding policies, raised their concerns to the local authority via the s42 process. For instance:

- SCAS submitted a safeguarding referral citing concerns regarding self-neglect and alcohol use on at least 5 separate occasions during the review period.[21]

[18] He made further allegation on the 12.06.21, 13.06.21, 05.08.21, 06.08.21 and 29.11.21

[19] Case records report calls on the 27.10.21, twice on the 28.10.21, 29.11.21, 25.12.21, 27.12.21, 16.01.22, twice on the 23.01.22- he was conveyed to hospital, 25.01.22- when he refused SCAS crew entry to examine him, 26.01.22- he refused to consent to a safeguarding referral, 01.02.22, 02.02.22, 03.02.22- refusing to allow SCAS access when they arrived,

[20] On 22.06.22 he called SCAS but was intoxicated and abusive when they responded to the call, the following day SCAS and police were called out on 2 and 4 occasions to assess his welfare.

[21] On the 01.04.21, 25.12.21, 23.01.22, 31.01.22 and 01.02.22

- SCAS also involved other agencies as required, for example calling on BFRS when Dylan had fallen, sustaining a head injury and could not get up so was blocking the door. In May 2022, following his admission into hospital with cellulitis SCAS again raised concerns regarding the unsanitary condition of the flat. They submitted a safeguarding referral to the Council and notified ASC hospital discharge team that they felt his home was a potential environmental health risk so were surprised he had no care package in place. Within the case notes, there was evidence of communication between the hospital discharge nurse, MKC Rough Sleeper Team and MKC Housing Solutions to look for alternative accommodation whilst Dylan was in hospital and that they recognised he would need 'wrap around support' to manage any tenancy. In June 2022 they involved his GP to request support. Dylan did speak with the GP (after the GP made a number of attempts) but he declined a referral to IAPT and ARC or a face-to-face appointment with the GP stating ''*let's leave it there doctor, you cant help me*'.[22]
- Safeguarding referrals were also made by his connections worker regarding concerns that he had expressed suicidal ideation or disclosed to her he had overdosed in February 2022 (on this date she appropriately referred this first to the police) and in June 2022. This safeguarding concern did not progress to enquiry.
- In addition to the calls noted in 3.12 above, the police attended his hotel to respond to safeguarding or welfare concerns in March 2021, twice in December 2021 (detailed in 4.16) and February 2022 (completing an ABCDE vulnerability assessment and submitting a concern). They also responded to the connection worker's concerns in July 2022 and found that he had passed away at his accommodation.

3.15. It was not clear from the case records how, or if, those raising safeguarding concerns received feedback on the action taken by the Council's adult social care department. In discussions with the reviewer practitioners confirmed the Council's adult social care department primarily responded to partner's safeguarding concerns by forwarding the referral for a social care assessment. Case records report social care assessments (under s9 Care Act) were completed:
- In April 2021 by the Community support team ['CST']. This was specialist social work team, based within social care but working closely with housing officers providing the Council's 'housing first' offer to those at risk of rough sleeping. The CST took a detailed history and advised he would benefit from a full assessment of his social care needs as he appeared to have eligible needs. He consented to them making further enquiries and explained he would like to be re-housed.
- The case was then allocated to the Assessment team for an urgent social care assessment which was conducted in August and signed off by a senior manager in September 2021. The assessment concluded he was not eligible for support with his care and support needs as he was currently managing independently. It was also noted that '*there was no indication that he lacked capacity*'[23] *and that there was no further action required from ASC*.[24]
- In July 2022, whilst he was admitted to MKUHT, the hospital adult social care team agreed to allocate a social worker following a request from MKUHT's safeguarding lead. He declined consent for a referral to be made for an assessment or an offer to arrange sheltered accommodation prior to his discharge. The discharge nurse explained to his connection worker that, given his refusal, they had '*no reason to detain him further as there are no safeguarding concerns, Dylan has capacity and can make his own decisions*.'[25]

3.16. In July 2022 he was discharged from hospital and later called 999 twice, first because he was '*lonely and needed someone to chat to*' and, subsequently, to complain about the service. He called 999 again the following day he was noted to have swollen legs and cellulitis but declined to go to hospital. He also tested positive for covid. His support worker had arranged to meet him

[22] Taken from the GPs case notes made available for this review.
[23] Taken from the ASC IMR prepared for this review.
[24] Taken from the ASC IMR prepared for this review.
[25] Taken from the combined chronology prepared for this review.

the next day. When he did not attend, she visited his flat and, in consultation with her manager, raised a request for a welfare visit from the police. She also called ASC safeguarding team who confirmed '*there had been a meeting today re Dylan on the way forward, if another safeguarding is received it will be escalated as there have been too many reported.*' Before this could be actioned, police found him deceased in his flat.

4. Analysis of Agencies' Actions

Local multi-agency responses to self-neglect, fire safety and alcohol dependency

4.1. Since 2015 the Care and Support statutory guidance[26] includes self-neglect as a form of abuse and neglect, noting that it covers a wide range of behaviours e.g. neglect of one's personal hygiene, nutrition, health or surroundings and hoarding. Whilst the guidance does not require that every case of self-neglect will require a safeguarding enquiry,[27] it does stress the importance of determining the adult's ability to protect themselves by regulating their behaviour and recognising that '*there may come a point when they are no longer able to do this, without external support*.'[28]

4.2. We know that older adults (65+) with care and support needs, particularly those who already exhibit self-neglecting behaviours, are more likely to die in fires. Over the five years to 2020, 70% of all fatal dwelling fires happened in a living room, followed by the bedroom (though in some of these incidents the living room was being used as a bedroom). The predominant source of ignition at fatal fires is smoking related (32% of all fatal fires), with a further 14% involving matches and candles. Heating and cooking equipment accounted for less than 10% each as the source of ignition for fires where there were fire related fatalities (including in dwelling fires).[29] Numerous SARs into fire deaths nationally[30] and national fire incident reports have identified the main contributory factors of a fire fatality are:

- how able the person was to respond to the fire (i.e. were they mobile; were they awake; were they impaired by drugs or alcohol);
- how early the fire is discovered, how quickly fire service is called and the arrival time/ response of the fire service;
- the materials involved in the fire (smoking, non-retardant bedding and pressure relieving mattresses, clothing or hoist materials, emollient creams all increase risk);
- the size and construction of the room/building;
- the proximity of the victim to the fire.

4.3. There were examples within Charles' case records of pro-active fire risk mitigation practice. For example, in January 2020 following a fire in a neighbouring street, BFRS completed a targeted interaction across Charles' area including his street to offer everyone a Home Safety Fire Visit. He, however, did not benefit because he could not answer his door. BFRS also have a dedicated fire safety officer who runs 'fire sense' talks for providers and will arrange free home safety fire visits. They reported, because of restrictions imposed by the pandemic, they have a significant backlog and currently try to prioritise those at highest risk. They are therefore dependent on partner agencies who are better placed to judge this risk (because they are in adult's homes and know if they have one or more risk factors) and communicate this to BFRS.

[26] Which accompanies the Care Act 2014 requires that all relevant partners with safeguarding responsibilities comply with the expectations set out within this, specifically the duties and powers described within chapter 14.
[27] In line with duties under s42 Care Act 2014
[28] pg.14.17 Care and Support guidance
[29] https://data.london.gov.uk/dataset/fire-facts--fire-deaths-in-greater-london
[30] The National SAB Chairs repository identifies 40 Safeguarding Adults reviews undertaken between 2019-22 where fire contributed to the harm suffered. Some of these will be thematic reviews, including multiple fire deaths.

4.4. BFRS also supply equipment to reduce the risk that fires might result in fatalities. Usually this is done as part of a home safety fire visit ['HSFV']. Whilst many of the frontline practitioners were aware of the HSFV offer, few had pro-actively requested this in cases where they had identified a high fire safety risk and did not believe they could access support if the adult did not consent to the referral. BFRS confirmed that, although their referral form asks for consent, they are able to provide direct advice to family members, carers or providers and can also make available equipment drops directly to carers if a less intrusive response is and more likely to result in some risk mitigation.

4.5. National research and local policy identifies heightened safeguarding risks attributed to alcohol misuse and resulting self-neglect.[31] In 2020 there were 8,974 alcohol-specific deaths in the UK, it is estimated that there are over 600,000 dependent drinkers in the UK with only 18% in treatment (a fall of 19% since 2013/14).[32] As well as causing enormous harm to individuals and families, alcohol has a significant impact on society, in part through the pressure it places on public services. In 2015, 167,000 years of working life were lost as a result of alcohol, and it has been estimated that the annual cost of alcohol to the economy is around £7 billion. In 2017 there were 337,000 hospital admissions caused primarily by alcohol. Alcohol is linked to over 50% of all violent crime (and a much higher proportion in the evening and at weekends), which equates to around 700,000 offences annually. The total social cost of alcohol to society is estimated to be at least £21 billion.[33]

4.6. Local guidance, most notably the decision support tool[34] and self-neglect and hoarding guidance,[35] advocate a multi-agency approach where risks are considered level 2 or 3. Given the descriptors within these tools and the facts known (or which ought to have been known) the threshold for a multi-agency safeguarding response was met in both cases. Practitioners are also reminded (within s4.4. of the local self-neglect guidance) to consider impact of their behaviours to neighbouring properties especially if there are fire risks. The guidance (at p9) sets out a need to consult with other agencies if (as they were in Charles' case) there are signs of burns within bedding or clothing. This document suggests the VARM process, rather than via a s42 safeguarding concern, may be appropriate, but lacks specificity of in what circumstances each pathway should be used as this is often best left to the professional judgement of practitioners involved in the case.

4.7. During the review period MK Together replaced the previous VARM with an 'Interagency Risk Management Protocol ['IARM'].[36] Senior managers explained that the previous Community MARAC and VARM processes were run through regular meetings with a large number of agencies attending and too little time to properly reflect on whether actions allocated at previous meetings had been carried out or if they had reduced risk. The new IARM protocol was intended to provide more flexibility to frontline staff from across partner agencies to lead on multi-agency risk management that was focused more directly on the relevant 'team around the person' rather than on those agencies who regularly attended Community MARAC or VARM. They explained having the VARM and s42 processes both referenced within local guidance caused confusion and meant that too often partner agencies relied on the assumption that if they had submitted concerns to the Council then this had met their safeguarding duty. They felt this undermined the principle (and expressed expectation within the new IARM protocol) that all agencies had duties to prevent harm and that all frontline practitioners should feel empowered to use the IARM

[31] See report by Alcohol change on 'learning from tragedies' (2019) https://alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017 . In addition, a search of the national SAR repository identifies over 260 cases where alcohol misuse was a factor.
[32] A rise of 18.6% from the previous year, this is 14/100,000 of the population. Taken from ONS data available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2020
[33] Alcohol Change UK report available: https://alcoholchange.org.uk/about-us/the-alcohol-change-report
[34] See page 17 of the decision tool available at: https://www.mktogether.co.uk/sites/default/files/2022-10/Decision%20Making%20Tool.pdf
[35] Available at: https://www.mktogether.co.uk/sites/default/files/2022-10/Self-Neglect%20and%20Hoarding%20Guidance.pdf
[36] Available at: https://www.mktogether.co.uk/sites/default/files/2022-10/Adults%20at%20Risk%20-%20Interagency%20Risk%20Management%20Protocol.pdf

protocol to mitigate risks rather than expecting the Council's safeguarding team to lead on all enquiries under the s42 process.

4.8. In discussions with reviewers, practitioners and senior managers explained too often with complex cases such as Charles and Dylan, agencies and adults at risk appear to be going round in circles with no real change. As noted above, the referring agencies were not made aware of any actions taken in response to their notifications of safeguarding concerns as feedback between agencies was poor. This is a common finding within SARs involving self-neglect. Preston-Shoot and Bray's research highlight that to overcome such barriers practitioners must acquire detailed knowledge of the range of legal duties and powers available to safeguarding partner agencies, confidence to apply these in complex and uncertain situations coherently so that solutions '*connect relevant legal rules with the professional priorities and objectives of ethical practice*'[37]

4.9. It is important to note that frontline staff from each team around Charles and Dylan did not have a complete picture of need, but, because all understood they were both at high risk, practitioners working directly with both adults had notified the Council of their safeguarding concerns. The Council accepted that no-one implemented either s42 processes or the IARM protocol in either case. They acknowledged these missed opportunities to bring together key partners to consider all of the risks and make plans to try and minimise these. For Charles, this would have enabled BFRS to advise about safer smoking options, fire retardant bedlinen and other crucial measures to reduce this risk. This would also have enabled a 'team around the person' [TAP'] to agree a plan of engagement. If necessary, this could have been by working through his most trusted carer as she had previously successfully persuaded him to accept additional necessary support (including increasing his care package to two visits a day). It should also have enabled a consistent message to him about duties owed to staff (explored later in paragraph 4.33). With respect to Dylan, it may have enabled partner agencies to have an accurate picture of his alcohol misuse and the adverse impact this was having for him, his neighbours and the public, given his frequent, inappropriate use of 999 services. Again, this is explored in more detail at paragraph 4.24. However, as no organisation had any legal powers to compel him to make use of support from ARC[38] it is pure speculation and therefore unhelpful to assume this would have resulted in a more positive outcome for Dylan.

Escalation routes if routine care planning interventions does not reduce risk

4.10. There isn't always a clear distinction in complex, risk cases between safeguarding responsibilities and partners statutory functions, including the provision of suitable accommodation or safe and appropriate treatment, care and support. Within the Care and Support guidance there is a clear statement that safeguarding is not a substitute for agencies complying with their own legal obligations. The Care Act also imposed clear legal duties on local authorities and 'relevant partners' to ensure cooperation[39] and elucidated this was not limited to s42 duties; rather the importance of inter-departmental cooperation across disciplines (e.g. housing and social care) and between functions (e.g. between commissioning and care management teams or third sector providers) is reinforced within accompanying statutory guidance and regulations. Where an adult has complex needs, local authorities are required to have in place '*arrangements to ensure co-operation between their officers, particularly between housing and social care, given that housing and suitability of living accommodation play a significant role in supporting a person to meet their needs and can help to delay that person's deterioration*'[40]

[37] Bray and Preston-Shoot [2016] Legal Literacy: Practice tool' Darlington: Research in Practice for Adults
[38] At most, the probation officer could have started the process to breach him for non-compliance, but it is unlikely the Courts would have (given his compliance with the restraining order from March 21) revoked their previous sentence and imposed a custodial order. Any community alcohol treatment order is made only with the consent of the offender.
[39] See s6-7 Care Act and 'Revisiting safeguarding practice' published by DHSC in March 2022
[40] 15.24 Care and Support guidance

4.11. Equally, there is guidance on the obligations to ensure continuity of care whenever an adult with care and support needs is moving into or out of prison or is 'medically optimised' for hospital discharge. Whilst there are examples of proactive work by front line practitioners to seek to prevent an escalation of need for both Charles and Dylan, both cases suggest that the information sharing and inter-departmental or inter-agency cooperation is not yet firmly established and that, as a result, significant safeguarding risks for those with complex needs remain unmet.

4.12. Guidance published by the LGA for SABs on a model of effective practice[41] was developed from thematic analyses of safeguarding adult reviews on self-neglect, housing and alcohol abuse. We have structured our analysis of the second theme in this review according to the four domains identified within this model, namely:

- Direct practice with individuals which is person-centered, provides a thorough understanding of needs and risks taking into account the impact of trauma and adverse experiences;
- Multi-agency, multi-disciplinary team around the person so that services work together to provide integrated care; information is shared and cases coordinated to utilise powers under all relevant legal frameworks;
- Organisational network surrounding the TAP providing supervision to promote reflection and analysis of case management, access to specialist legal, safeguarding, mental capacity and mental health advice and developing commissioning to respond to needs for those experiencing multiple exclusion homelessness;
- Clear governance to promote locally agreed processes and procedures, monitor effectiveness of provision and that can hold partners to account for practice standards.

Direct work with the Adult

4.13. Interactions with Charles focused heavily on the support that he was willing to accept. Practitioners reported anxiety that, if they pushed too hard with him to accept additional support, he may reject all interventions and that this would leave him at greater risk. BFRS raised concern that his micro-environment contained a large number of significant fire risks. In addition to the lighter fluid on his bed and lack of fire-retardant bedding, there were candles and overloaded sockets, limited egress and emollient creams had been used on his legs. Whilst they understood he had declined offers of advice directly from BFRS, they questioned whether it would be possible to require greater education of fire safety risks to all those who work directly with adults needing care and support so that they feel more comfortable about the steps they can lawfully take to reduce risk.

4.14. Similarly, those working directly with Dylan demonstrated persistent, non-judgemental concern. They provided him with appropriate care and options for rehousing, taking into account the resources they had available. Consideration was given to identifying suitable pathways to assist him to access specialist support (e.g. probation and ARC worked together following his community order to establish appropriate treatment options), housing and CRT identified his likely needs so he was allocated a Connection Support worker. Police and Ambulance staff responded to each call in line with their professional duties, despite, occasionally receiving significant abuse from him.

Team around the Adult

4.15. There was a clear understanding within the team around Charles, including his brother, carers, district nurses, social care and his GP, that unless he demonstrated a lack of capacity, they had no powers to compel him to receive support. As noted below, they are to be commended for the

[41] Michael Preston Shoot, 'Adult Safeguarding and Homelessness: A briefing on positive practice [2021] LGA available at: https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-briefing-positive-practice

adjustments they made to their usual practice to minimise the risks his continued smoking whilst bed bound posed. However, there was also disquiet among the team that more was needed to reduce this obvious risk. Sadly, few understood how to escalate their concerns to other relevant partners who may have been able to provide practical solutions to reduce the risk (most notably BFRS) or beyond their direct line management. There was no evidence that practitioners (singularly or collectively) consulted MK Together policies or guidance to better understand how they could escalate their concerns that the normal interventions offered were not mitigating risks.

4.16. In Dylan's case, continuity of care was frustrated as those working directly with him were not fully aware of each other. Those responding to the frequent 999 calls were (understandably) usually unaware of the wider treatment and support Dylan had available, though there were examples of good practice by the Connections Support worker and 999 responders communicating effectively where she had raised a request for assistance to check on his welfare.[42] There were also examples of good practice of inter-agency safeguarding practice (e.g. police responding to antisocial behaviour complaints who took time to investigate if cuckooing was a risk, communicate their concerns to neighbourhood policing, feedback their actions to the Connection Worker and Housing provider). However, there were missed opportunities to bring together a more cohesive team, for example probation and ARC had important powers (alcohol treatment order) but were unaware of the full extent of the adverse impact of his drinking. In addition, the handover between the adult social care's CST team (set up to assist with adults who self-neglect) to a more generic team meant (almost inevitably) information regarding his executional capacity to manage his care needs was lost. For example, the social worker tasked with completing this assessment was not aware he had been evicted from a number of hotels or his antisocial behaviour. This assessment was conducted during lockdown over the phone and took no further action after Dylan reported he had no needs and was '*a proud man who reported he didn't need support... his focus was on re-housing.*'[43]

Organisational Support

4.17. There were examples within both Charles and Dylan's case files of managerial guidance and oversight. For example, the team manager advising that Charles' social care review should focus on self-neglect and fire risk. It is also notable that all partner agencies would have faced exceptional service pressures during the review period because of the necessary restrictions and significant increase in demand across the public sector imposed by the Covid Pandemic.

4.18. It is also clear that during this review period and since, partner organisations have continued to finesse their multi-agency responses to these risks. For example, the Housing First Rough Sleeper Pathway and Panel were only established in October 2021 and was in its infancy. ARC spoke of how much progress has been made within their teams on the development of relational practice both with their clients and other practitioners working alongside them. BFRS reported they track HSFV referrals to ascertain if the training they have provided to partner agencies has impacted on practice change. This is good practice and should be reported regularly to MK Together as an indicator of effective preventative safeguarding actions.

4.19. Senior managers and practitioners were also open about ongoing challenges for all those involved in supporting adults at risk in how they interpret legal obligations where there appears to be direct conflict between the obligations to adhere to capacitated refusals of support and the obligation on public bodies and MK Together partners to safeguard. This is explored later in response to the third and fourth themes.

[42] On the two occasions she made calls to the police to carry out a welfare check, this was necessary and proportionate given what she had cause to suspect. She did not have legal powers to enter his property and, as such, was reliant on the police to use their powers of entry (s17(e) PACE) because there was reasonable cause to suspect a risk to life.
[43] Taken from discussions at the practitioner event.

4.20. Many of those involved in this review spoke of the loneliness of carrying such risks with little power to enact change or improve outcomes. There was recognition that workforce pressures and high caseloads made this much more difficult, meaning that too often difficult cases were passed between services. They spoke about how, during the pandemic some senior strategic leaders came out with practitioners to speak with adults at high risk of self-neglect and how supportive those actions were. They also spoke of the benefit they found reflective practice workshops to help them to problem solve. These had fallen away during Covid, in part because more staff work remotely but mostly because of caseload pressures. There was a sense that strategic leaders understood the impact that such challenging cases had on staff wellbeing, but there was still insufficient opportunities or infrastructure in place to ensure this remained an operational priority.

4.21. Findings from these reviews should also inform strategic commissioning. Staff working with Dylan spoke of how much harder it was to work with him, given his pattern of drinking, when he was placed in temporary hotels with other adults suffering substance abuse. They explained they had already adapted practice to avoid placing people with high levels of drug use within city centre placements to reduce this risk, but argued their input would have more positive outcomes if people had access to smaller, supported housing units.

Accountability and Governance

4.22. The purpose of a model that requires robust supervision and management oversight of frontline decision making (as well as access to sound policy frameworks and specialist legal advice) is to ensure that local processes and policies are used effectively to enable statutory obligations to be met. For this to impact on the operational delivery, MK Together partners should consider how they receive assurance that the IARM protocol or s42 safeguarding processes are removing or reducing risk. Currently, NHS Digital require all local authorities to report data on key performance adult safeguarding indicators [known as 'SAC' returns], these include if s42 safeguarding enquires remove or reduce risk. In 2021-22 the Council received 1,314 concerns, though only 420 of those converting into safeguarding enquiries. Of those only 5.5% involved self-neglect. As Charles and Dylan's cases demonstrate, rarely are self-neglect safeguarding concerns raised by partner agencies responded to via the s42 pathway. It is, of course perfectly lawful to develop alternative, more effective and efficient processes to manage such risks. The IARM is such a process, but MK Together must secure ways to ensure this protocol is disseminated and embedded into local partners operational practices. Presently, as Charles and Dylan's cases demonstrate, partner agencies' internal safeguarding policies appear to make no reference to the IARM protocol and instead require their staff to submit a safeguarding concern.

4.23. MK together partners must also agree devices to monitor the effectiveness and hold agencies to account. One way to do this might be to require those using the IARM protocol to report this to the Council as a safeguarding enquiry that is to be recorded as 'other' within the SAC dataset so that it is possible to ascertain which agencies are leading on these responses (and which aren't- suggesting a possible training need) and whether the IARM protocol is successfully reducing risk.

Addressing risks identified by frequent, inappropriate use of emergency services

4.24. Dylan described himself as a binge drinker. He would report abstinence to ARC and only attend sessions online, giving a misperception that he was coping. This did not reflect the wider picture of police and ambulance reports whereby he would frequently contact 111 and 999 whilst intoxicated which increased the risk of harm to himself as ARC were unable to establish an accurate account of his consumption and provide targeted interventions. At the time, service delivery (due to COVID regulations) prohibited face to face direct contacts so he could not be breathalysed. ARC staff were fully aware, including during the pandemic, that the lack of in-

person support would increase risks of non-compliance, but were required (because of the greater risk of Covid cross-infection) to apply the law.

4.25. SCAS did recognise the increasing risks both to Dylan and to the public and responded in line with their policies by referring each relevant incident as a safeguarding concern to the local authority and by notifying their own organisation that he was a high intensity user. This good practice by frontline crew was understood by partners, including his probation officer and provided part of the rationale for his recall to prison. However, later within the review period, the crews action did not trigger a multi-agency/ professionals discussion and all those in the review felt that this was a missed opportunity. MK Together, particularly the Council, ICB and SCAS's designated safeguarding leads, should explore how to better integrate internal 'high frequency user' policies into the IARM process. Consideration should also be given to how issues such as high frequency use of 999 is relayed to GPs so that they are aware of the deterioration in mental and physical health.

Balancing obligations: respecting capacious decisions where the adult at risk's ability to keep themselves safe is likely to fluctuate.

4.26. For many years research findings into self-neglect and/or alcohol abuse[44] have warned against practitioners assuming individuals are making a 'lifestyle choice' without further exploring their ability to protect themselves. This is important in the context of safeguarding functions because it is the 'ability to protect themselves' rather than the capacity to make decisions that is the basis for safeguarding legal duties under s42 Care Act 2014. This duty sits alongside a general duty to carry out all social care functions in a way that promotes an adult's wellbeing.[45] The 'wellbeing principle' includes a focus on personal dignity, choice and control, but there '*is no hierarchy, and all should be considered of equal importance when considering 'wellbeing' in the round*'.[46] As such, equal weight should be attributed to duties to protect health and against abuse or neglect. Ultimately, the duty to protect life (protected under article 2, Human Rights Act 1998) requires all public bodies to do whatever is within their legal powers where risk is real and imminent to act to reduce risk.

4.27. Practitioners and senior managers, whilst recognising a lot of good practice in both cases, confirmed there were real challenges in the application of this complex legal framework in practical situations, particularly because the Pandemic placed increasing pressures on resources across public and provider sectors.

4.28. We know from extensive research[47] that ascertaining a person's agency in complex situations can be extremely difficult, particularly where there is strong evidence of fluctuating capacity (often associated with self-neglect and/or alcohol dependency) or a divergence between how an adult 'performs' during an assessment process and how they execute decisions in real life situations. Within their practical guide for practitioners, Ward and Preston-Shoot[48] list the physical and emotional conditions most dependent drinkers display to challenge the idea that alcohol dependency is a self-determined choice and remind practitioners that NICE guidance[49] advises assessments of capacity should consider observations of the person's ability to execute decisions in real life situations. NICE advises where there is evidence (e.g. from previous case

[44] Bray, Orr and Preston-Shoot (2015) 'Serious case review findings on the challenges of self-neglect: Indicators of good practice' Journal of adult protection 17,2, 75-87
[45] S1 Care Act 2014
[46] Section 1.6 Care and Support Guidance, DHSC available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#general-responsibilities-and-universal-services
[47] See, for example, Martineau and Manthorpe [2020] 'Safeguarding adults reviews and homelessness: making the connections' Journal of Adult Protection, 22,4, `81-197 and Martineau, S. J., Cornes, M., Manthorpe, J., Ornelas, B., & Fuller, J. (2019). *Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews*. London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.
[48] Ward and Preston-Shoot [2021] '*How to use legal powers to safeguard highly vulnerable dependent drinkers*' for Alcohol Change UK, available at https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf
[49] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.

history) that outside of an assessment environment the person is not able to understand or weigh up information to enact a decision, this should be thoroughly explored and could trigger further duties to ensure an adult is safe.

4.29. Guidance on what works to safeguard those at high risk due to self-neglect or addiction advises practitioners to ascertain the adult's reasons for behaviours and discuss with them other options they see themselves as having. Again, case notes evidence attempts by numerous agencies to have these conversations with both Charles and Dylan. Equally, there are frequent examples that practitioners provided persistent, compassionate support and adapted their usual practice in an effort to mitigate some risk. As such there was no evidence of unconscious bias sometimes identified in such reviews, e.g. a belief that dependency is self-inflicted or a personal choice, resulting in a mistaken belief that those with dependencies do not deserve care.

4.30. It was apparent, however, that in both cases practitioners believed *'any imposition of care* [was] *an infringement of their rights*'.[50] Legal powers under the Care Act arise whenever a person is 'unable' to meet the 10 social care outcomes or protect themselves from abuse or neglect. A person is 'unable' if it takes significantly longer or they cannot do so without assistance, without significant pain, distress or anxiety, or without endangering their health and safety or the health and safety of others.[51]

4.31. Practitioners recognised the risks posed by Charles' heavy drinking and smoking despite his immobility. His capacity to accept the risk to himself was assumed. Practitioners explained that they had no reason to doubt he had capacity and as such did not complete assessments despite obvious risks regarding his ability to stay safe. There was evidence that his carers raised concerns, for example in February 2022 they asked for adult social care's older people team and were told to alert his GP as the issues was 'predominantly medical'. It was noted that involving his GP was contrary to Charles' wishes, but necessary in the circumstances and thereafter there was evidence of good communication between the carers and his GP with respect to obvious medical risk. Practitioners explained it was not always clear who was best placed to undertake capacity assessments, particularly if the issue in question cut across medical and social care needs. They explained, what was needed was clearer guidance from those with professional qualifications or expertise in clinical conditions (especially substance misuse) so that they could better understand what risks to look out for and how to manage risks before the adult is in crisis or suffers harm.

4.32. To mitigate some risks, reasonable adjustments and significant efforts were made by his care providers to encourage him to accept support to reduce risks associated with immobility (e.g. pressure care) or poor nutrition and personal hygiene. It is less clear if they took steps to mitigate risks posed by his smoking. Practitioners spoke of looking to more senior staff to propose options, but there was no evidence of this or sufficient organisational support to ascertain what lawful steps could be taken (e.g. fire retardant bedding, purchasing safer lighter fuel).

4.33. BFRS spoke of the obvious carer distress they had encountered when attending several fire deaths recently. They explained, coming upon a fire death is distressing for trained firefighters and they have systems in place to ensure they are properly supported. They questioned whether care providers would have the same resources or infrastructure. This prompted a discussion with practitioners about how Charles would have reacted if risks to those carers he did appear to respect were highlighted. There was acceptance that this had not been considered, but that this should be attempted with future cases, not least so that a more rounded view of the person's capacity and ability to stay safe could be explored and the person's views properly documented

[50] Ward and Preston-Shoot [2021] '*How to use legal powers to safeguard highly vulnerable dependent drinkers*' for Alcohol Change UK, available at https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf (p10)
[51] within pg6.105 of the Care and Support guidance

and shared with the team around them and, for those organisations that would carry ongoing high risk, with their senior managers.

4.34. BFRS advocated for much more fire safety awareness to be embedded into contracts with social care providers. They questioned if any training was made available to care staff or if the Council or ICB included this as a mandatory requirement within their contract. BFRS felt that would significantly reduce risk. Such organisational support is essential if, as is increasingly likely, providers too will be held to account for poor safeguarding practice.[52] ICB and Council contracts should also contain information to care providers on escalation processes (e.g. through the self-neglect policy and IARM protocol).

4.35. It is important to note that Charles owned his own home and lived alone. As such the significant changes to improve fire safety following the Grenfell fire through the imposition on 'responsible persons' to carry out fire safety risk assessments[53] would not have applied. Practitioners were aware that, had his hoarding been significantly worse, legal powers under the Environmental Health Acts or Housing Act 2004 may have been applicable. There is, we believe, a pressing need to close a lacuna in the law where no-one agency has powers to compel actions to reduce fire risk. This is addressed at Recommendation 3.

4.36. Equally, within Dylan's case notes the risks associated with fluctuating capacity, poor impulse control, self-neglect and his occasional suicidal ideation were recognised. For example, in November 2020 he was referred for an assessment by staff within the acute hospital to CNWL's in-reach mental health liaison nurse. Case files confirm discussions with him included consideration of his Dylan suicidal ideation concluding lower risks because of his '*family is his protective factor*.'[54] It is important to note, the Mental Health Act 1983 ['MHA'] expressly excludes compulsory detention for assessment or treatment solely on the grounds of alcohol dependency. If someone has a disorder of the mind related to alcohol use, for example alcohol-related brain damage, acute confusion, severe depression or psychosis, it is possible to use legal powers under the MHA. But as Preston Shoot and Ward make clear *'this will not be, and should not be, a simple or frequent option. It will generally require considerable multi-agency discussion to demonstrate the need for this route*.'[55] It is a legal requirement for practitioners using MHA powers to pursue the least restrictive option.

4.37. Throughout the review period Dylan often failed to comply with his accommodation providers' reasonable behavioural expectations and, consequently, risked eviction. It is apparent from case notes that partners did question if Dylan had capacity to manage a tenancy, but agreed to adopt a rights-based approach by supporting him through their 'housing first approach. This was complimented by the Council's development of a specialist adult social care Community Support Team ['CST']. This model of best practice allows for professionals to develop consistency of practice across different disciplines, enabling practitioners to build relational practice with the adult at risk and across the 'team around the person'. Unfortunately, this was undermined when CST believed it was necessary to refer to a mainstream adult social care team. For Dylan (and the team around him) this resulted in an inconsistent message that he did, then did not have eligible needs. It remains difficult to understand the rationale for this change of position. Senior managers accepted this was a mistake and that CST should have completed this assessment to reduce duplication and prevent delay. Case records indicated that decision may have been because of a misperception that because he was presently within the 'housing first' pathway this would supersede duties owed under the Care Act.

[52] Increasingly Coroners are using their legal duties under reg28 of the Coronial (Investigations) regulations 2013 to request providers confirm actions taken to prevent future deaths.
[53] Fire Safety (England) Regulations 2022
[54] Taken from the combined chronology submitted for this review
[55] Op Cit, p9

4.38. It is our considered opinion that practitioners and senior managers fairly concluded it would not be proportionate or necessary to use legal powers under the MHA or Mental Capacity Act 2005 to compel either Charles or Dylan to accept support on terms that removed all risk. In *Wye Valley NHS Trust v B* [2015] the Court of Protection reiterated that best interest considerations under s4 MCA were *'not an academic issue, but a necessary protection for the rights of people with disabilities. As the Act and the European Convention make clear, a conclusion that a person lacks decision-making capacity is not an 'off-switch' for his rights and freedoms.'*

4.39. In *London Borough of Tower Hamlets v PB*[56] Mr Justice Hayden held that the fact PB seriously overestimated his ability to keep his alcohol use under control was not enough to establish a lack of capacity. He warned that not every addict in some degree of denial can be regarded as incapacitous. He also explained the requirement to be able to understand the "reasonably foreseeable consequences" of a particular decision does not mean that the relevant person must accept the professionals' view that they will not be able to control their drinking.

4.40. In Charles case, practitioners carefully weighed up how to provide necessary care in a manner that would not result in his refusal of any offer of support. They demonstrated flexibility to attend to his care needs at a convenient time for him or so that other professionals (such as the GP or district nurses) could gain access. Ideally, the same considerations would have facilitated BFRS and, given his previous intervention, his brother to have taken action that would have mitigated some of the fire safety risk. At the very least, this would have provided guidance and support to those working directly with Charles so that they were confident they had explored all legal powers to act and that senior managers within their organisation and partner agencies were aware of, and managing, remaining risks.

4.41. To reduce risk for Dylan, agencies would have had to impose wide controls on his freedoms to ensure he did not drink and to enable him to engage effectively with ARC. The proportionality of such restrictions would have to be weighed against the positive and negative impact these would have on his wellbeing. Anyone authorising a deprivation of liberty would need to be satisfied that harm caused by imposing restrictions against his wishes, were outweighed by the benefits. As set out above, even the alcohol treatment order could not be enforced against his stated will as these are only made by Courts on the basis of willing engagement because of empirical research which demonstrates compulsion is rarely an effective motivator to secure rehabilitation in respect of alcohol dependency.

4.42. Consideration might want to be given by MK Together (working with BFRS, police and wider partners) of what support should routinely be available including to staff working in provider and the third sector to de-brief and provide ongoing support to those affected by the death of an adult at risk in circumstances such as Charles and Dylan. This could be monitored with the inclusion of an additional question within the Case Review Panel's referral form asking what support has been offered to frontline practitioners following the incident.

How can MK Together evaluate the success of each member organisation's actions following a SAR; what more might be needed to ensure sustainable practice improvement?

4.43. Since SABs became statutory bodies in 2015, there have been significant pressures experienced by most (if not all) member agencies as a result of austerity, the Covid-19 pandemic and the present cost of living/ workforce capacity issues. Those pressures coincide with a time of significant structural change affecting all three statutory safeguarding partners. Despite this, to implement learning from previous safeguarding adult reviews, MK Together has undertaken significant work to remodel the guidance available to partner agencies in a way that better frames the multi-agency responsibilities as set out within the Care Act 2014. However, what is

[56] [2020] EWCOP 34

clear from this review too few frontline practitioners from 'relevant partners'[57] are aware of the changing nature of their responsibilities.

4.44. There is evidence, within Dylan's case records, that neither frontline nor operational team managers had been made aware of the policy changes to a IARM protocol. For example, the Council's RST (housing first team manager) asked for a VARM meeting in regard to Dylan in February 2022, five months after the new IARM protocol was introduced. This good practice in requesting a multi-agency meeting to address known risks was not responded to, nor did any of those contacted reply to this request. The team manager also highlighted that it was only during this review that she (and her team) were made aware of Dylan's past offending behaviours. This not only undermined their ability to meet their statutory duties to him, it also undermines the Council's ability (or third parties commissioned by them) to meet obligations towards the safety of their employees. Senior managers from commissioned services explained that previously there was much clearer guidance from commissioners on what support they could expect from the Council as third-party providers carrying out statutory functions. In recent years, perhaps because of significant structural change necessitated because of the austerity programmes, this has become weaker. They acknowledged the impact that the pandemic had on commissioners' ability to meet the complex and competing priorities during this review period, but equally highlighted how this should routinely form part of business continuity plans. ARC were particularly affected as they had assumed responsibility for the service from another third sector provider at the start of the pandemic in March 2020 and had been unable to access any clients' past records as the electronic case records from the previous provider were not made available as part of their handover.

4.45. MK Together intend for the new IARM process to support a cultural shift in practice so that 'safeguarding adults' is part of every agency's core business. To achieve this, it is important to recognise that this will mean a substantial but necessary change in understanding across all safeguarding partner agencies and the Council. Prior to the Care Act, safeguarding adults duties were predicated heavily on social care taking responsibility for responding to abuse. Section 42 Care Act widened this responsibility considerably, so duties are owed equally by 'relevant partners' not only to report abuse, but also to prevent abuse/neglect occurring or respond effectively in line with each organisations legal duties and multi-agency policies if it does. When those new duties were introduced in 2015 they were grafted onto existing organisational structures during a policy of 'austerity' within public services. In addition, public sector resources have also been adversely affected by the Covid pandemic and significant workforce capacity issues as well as the current cost of living pressures. Consequently, as seen in both these cases, most relevant partners still follow a 'recognise and report' model of safeguarding. MK Together may wish to highlight, particularly to key statutory partners, that this model is not in line with their Care Act obligations and unlikely to be sustainable given the exponential rise in safeguarding concerns notifications since 2016.[58]

4.46. It is undoubtedly difficult to embed culture change and learning from SARs across multiple organisations and disciplines. The National Analysis of SARs (published in 2020) identified a number of common pitfalls and highlighted how fundamental it was for effective safeguarding practice to have solid organisational support around the team providing direct work to protect an adult at risk. It identified poor practice often occurred because during the initial assessment/enquiry process practitioners did not clearly check that others had understood their communication, noting too often there is an assumption that information shared is information understood. This can be amplified if there is overreliance on IT systems across multi-agency practice. Similarly, too frequently practice reviews reported insufficient support/supervision to enable practitioners to work effectively with adults at risk and family members who are

[57] As defined by s6(7) Care Act 2014, but this should be widened to include all MK Together member agencies who have agreed the multi-agency policies and practice guidance.

[58] According to NHS Data Safeguarding Return[58], since 2016/17 there has been a 45% rise in the rate of safeguarding concerns referred to local authorities nationally in England (from of 839/100k to 1218/100k in 2021/22).

uncooperative**,** ambivalent, confrontational, avoidant or aggressive. The report also warned that case responsibility is diluted in the context of multi-agency working, impacting both on referrals and response. Too often adults at risk involved in SARs were signposted to other agencies, with no follow up and insufficient checks to ensure those agencies could meet the needs/ risks identified. A key theme in SAR analysis was the lack of management oversight of key decisions.

> *'Only by using an approach of active leadership, supported by internal audit and responsive escalation routes, can an organisation ensure the needs of adults at risk can be responded to with timely approaches consistent with agreed policies and procedures.'*[59]

4.47. Traditionally, boards track if action plans have been completed (often through a 'RAG' rating). A whole system approach to achieving the kind of change in practice desired by MK Together would be to RAG rate actions according to risk (outcome rather than output), using a risk matrix to assign a risk rating to each action based on the risk to adults in terms of the likelihood and seriousness of that risk, including the number of individuals it was likely to impact. Thinking about the root causes when considering the learning and recommendations from SARs may help. Issues identified as causative will indicate a higher risk than those that were more incidental. This will also enable partners to identify barriers to reducing risk beyond their immediate control or that conflict with other priorities for partners. It will also assist MK Together members agree mitigation actions to address those. Risk rating in this way would have benefits, firstly it would enable partners to identify how to prioritise resources according to the highest risk, secondly it would enable the partnership to assess whether the action plan was succeeding in lowering those risks over time. Whilst for many risks, it may not be possible to eliminate risk of harm entirely, use of a risk matrix enables change in risk to be mapped over time. It is obviously essential that actions plans continue to contain high level strategic actions to achieve ambitious safeguarding aims, but building into strategic decision making opportunities to check what impact there is and if mitigation has been activity considered (e.g. as is done to ascertain the equality impact of Council decisions) could enhance deliverability across all agencies.

4.48. Safeguarding Boards have long found it difficult to demonstrate positive impact from their work. They have no legal powers to compel members to commit resources so are reliant on interpersonal relationships to secure commitment and participation on the collectively agreed priorities. Added to this, the original set up of SABs expected multi-agency partnerships to seamlessly graft onto single agency structures.[60] This was not always achieved so current workforce pressures present further significant hurdles. In this context, achieving the shared aspiration to embed the new IARM protocol will therefore require more 'buy-in' from across partner organisations than might be reached simply by disseminating the document to member organisations' designated safeguarding leads. Importantly, the partnership will need to agree an approach that can efficiently monitor the whole system, such as by RAG rating outcomes, so they can identify as soon as possible if actions are not resulting in positive change or risks are continuing to escalate and change its action plan to try to reduce that risk. The action plan should not just monitor whether a policy has been agreed and circulated, it should track whether that policy has made adults safer. To evidence this, partners must carefully consider what data or other evidence is available (or needs to be collated going forward) to evidence the changes in outcomes.

[59] 'Analysis of Safeguarding Adult Reviews (2020), M. Preston-Shoot et al. Paragraph 7.3.4. Available at: https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

[60] 'Making any difference? Conceptualising the impact of safeguarding adults boards' Preston Shoot, JPA, Nov 2019, https://doi.org/10.1108/JAP-08-2019-0025

5. Conclusions

1. Do agencies use multi-agency forums to share information and coordinate responses where there are persistent concerns regarding self-neglect (including substance misuse and fire safety risks), even if no obvious crisis?

System Finding: Presently, MK Together's self-neglect policy and IARM protocol provides a basis for developing a more system-wide approach to safeguarding those at risk of self-neglect, but this is not embedded and does not address the organisational responsibilities for supporting any multi-agency team around the person. Nor are there clear mechanisms currently with respect to providing organisational support or oversee the governance of those processes.

Recommendation 1: Given the challenges experienced by ARC in Dylan's case, the Council and ICB should provide assurance that whenever a new service is commissioned, especially if this is intended to provide statutory functions for assessment, care planning or safeguarding, the contract of service should provide clear obligations for senior management to induct key personnel within the new services. This induction should include an overview of expectations within key MK Together policies (adult safeguarding policies and procedures, the decision tool, escalation protocol, IARM protocol). The new service leads should be introduced to senior leaders and significant persons within partner agencies. MK Together should also seek assurance that business continuity forums receive reports on service continuity plans for high-risk practice areas to ensure client information (including relevant history) is accessible to the new service.

Recommendation 2: MK Together should ensure that links to the Fire Sense training and HSFV referral form are accessible on the partnership website. They should also explore ways to report to the partnership how well this offer is used by partners to mitigate risks and if they have identified additional training needs within partner agencies. Partners should explore a practical, lawful way to share information with BFRS on those at highest risk who are known to adult social care so that HSFVs (and equipment) can be targeted to those most at risk.[61]

Recommendation 3: Given the high number of fatal fires involving adults with care and support needs and the complexity for frontline practitioners mitigating risks when adults have capacity and decline preventative support, MK Together should explore if regional or national SAR recommendations to improve outcomes would be more achievable if Fire Services were given legal powers to apply for Fire Safety Prevention Orders, similar to legal powers environmental health officers have to prevent harm or public nuisance.

[61] This is routinely done in other parts of the UK with fire services. There are also mechanisms in place to notify utility companies (Gas, Water, Electricity) of vulnerable residents who would be a high risk if access to energy was restricted so that they can consider vulnerability when carrying out their functions.

2. Is communication effective and do agencies use existing policies and procedures, including under s42 and MK Together's decision tool, where routine care planning interventions have not removed or reduced the risks?

System Finding: Good systems to share information between partner agencies regarding alcohol misuse and/or fire safety risks are not yet established. Developing this as a system wide approach, would provide opportunities to improve practice regarding risk mitigation between partner agencies. MK Together partners should agree any mechanism for information sharing gives priority to those with one or more high risk indicator. They should also agree to collect KPI data to enable MK Together to demonstrate improvements in practice across member organisations in response to new policy initiatives or local SAR reports.

Recommendation 4: Where high risk is identified, those leading on providing accommodation, care or treatment convene a meeting drawing on expertise within the partnership (e.g. ARC/ BFRS) in line with IARM protocol to agree a risk management plan, advise on risk mitigation options and, if warranted, provide any necessary protective equipment.

Recommendation 5: MK Together should urgently strengthen their data from partner agencies so that this includes indicators about who is referring concerns or initiating multi-agency protection planning using the IARM protocol. This will enable the partnership to '*hold partners to account and gain assurance of the effectiveness of its arrangements*'.[62] For example, it would be prudent to identify a means of reporting how many concerns or IARM referrals are graded against green, amber and red descriptors. MK Together should also receive a report on the timeliness of response within those categories and, as it does for s42 enquiries, data on the number of IARM cases where the risk is removed, reduced or remains. This could be achieved by requiring IARM cases to be reported via the s42 process as 'other enquiry' or as a 'managed concern'.

3. Given the importance placed on prevention and de-escalation of needs within strategic plans and legislation, how can we support frontline staff when they are working with adults with care and support needs who misuse substances and are at risk of abuse (including self-neglect and suicide); are services flexible to make reasonable adjustments when alcohol/drug use is a factor or are services/ specialisms resulting in barriers to effective interventions?

Finding: Whilst there was evidence that practitioners working with Charles and Dylan took action and made reasonable adjustments in their usual service delivery, this was frustrated because of a lack of apparatuses to build into existing organisational support infrastructure (i.e. workforce development requirement, supervision, quality assurance requirements) opportunities to disseminate and socialise new policies and guidance.

Recommendation 6: MK together partners should agree mechanisms for receiving assurance from partners on the effectiveness of that infrastructure on implementing practice change. As an example, many partner organisations will complete a self-assessment on their safeguarding practice so this (or action plans from SARs) could be adapted to ensure this also captures information on the quality of organisational support. This may also enable cross agencies to work collaboratively (e.g. triangulating data from BFRS on which agencies refer for HSFV) to assist commissioners to better understand training needs of their providers.

4. Where adults at higher risk of a fatal fire or overdose and are not compliant with preventative interventions to reduce risk, is their capacity to keep themselves safe routinely assessed; do partner agencies have systems in place to monitor the quality of those assessments and decision-making following completion of capacity assessments?

[62] Pg 14.139 Care and Support Guidance

System Finding: Weighing up the myriad of powers and duties owed by statutory partners and providers is difficult. It requires a high level of skill, persistence and compassion. As recognised throughout this review, frontline staff demonstrated persistence, ingenuity and compassion when providing care and support to Charles and Dylan. However, they lacked the detailed knowledge that would have been available had multi-agency risk management processes (either under s42 or IARM protocol) been applied.

For the reasons given within the main report, it was disproportionate and therefore unlawful for practitioners working directly with Charles and Dylan to have used powers under the Mental Health Act 1983 or Mental Capacity Act 2005 to compel them to receive support to mitigate all risks. It is therefore reasonable that practitioners relied on residual legal powers to offer support to address known safeguarding risks. However, it may have been much more apparent to practitioners and senior managers that either the s42 or IARM process should have been triggered if Charles and Dylan had been directly consulted about their ability to stay safe. A more robust recording of their views of known risks and a multi-agency view of their inability to undertake actions that would protect their own safety and the health and safety of others was needed.

Recommendation 7: Partner agencies should provide assurance that they have revised internal safeguarding policies to include reference to the IARM protocol and, referencing this SAR report, explain the distinction between capacity and someone's ability to stay safe.

System Finding: Presently there is insufficient evidence that an adult's capacity or, separately, their ability to keep themselves safe is routinely considered and recorded. Agencies involved in this review rely on audits to ascertain compliance with MCA and safeguarding duties, but have no established mechanism to routinely report issues to MK Together. It is also unclear to practitioners who is responsible for determining whether an adult can stay safe, but generally practitioners involved in this review felt that this would be undertaken by adult social care staff as part of any safeguarding enquiry. Senior managers and panel members submitting information to this review accepted that, had s42 enquiries commenced in either case this would likely have provided opportunity for agreement on how best to ascertain if they could weigh up and act on risk information. All involved in the review agreed that this agreement would need to be informed by those who know the adult best and not simply 'outsourced' to social care, particularly if this involves information beyond their expertise.

Recommendation 8: MK Together partners should review their training offer to ensure that this includes assimilation of the decision tool and lessons from this review regarding the importance of exploring the adult's awareness of risks to themselves, the public and carers. Commissioners should provide assurance that this is now required within all contracts for new services. Monitoring should be robust, with commissioners identifying KPIs (e.g. audits of capacity assessments or IARM/s42 concerns, provider use of IARM or escalation protocols etc) that could evidence improvement in practice.

Recommendation 9: MKT consider amending s42 concerns referral form to include a prompt for other agencies/practitioners to list why they believe the adult may be unable (even if capacitated) to protect themselves from harm.

5. How do partner agencies disseminate new safeguarding policies or good practice guidance; are the processes for monitoring practice improvement robust; what more might be needed by MK Together and partner agencies to ensure sustainable practice improvement?

System finding: Key partners, including commissioned services, responsible for needs assessment and risk mitigation (e.g. Connections Support and ARC) were largely unaware of the change in policy. During discussions with senior leaders, it was noted that this change had been highlighted previously by another SAR underway locally. Some expressed frustration that failure to embed (or socialise) new policies within partner organisations resulted in overburdening social care with risks that were more appropriately met by other agencies (e.g. for Charles, by BFRS and for Dylan, by ARC) because they

could be re-framed as ‘safeguarding’ when these are better managed as complex cases within statutory care or treatment pathways. Practitioners also recognised that it was difficult, to balance current workloads and the highly complex nature of cases seen since the start of the Pandemic with expectations they will have time to reflect on whether they are properly implementing new local policies, best practice or case law. They asked for an acknowledgement that this overburdening of expectations onto frontline practitioners needed to be addressed by those not on the frontline, but who hold responsibility for providing organisational support or governance roles within the multi-agency safeguarding infrastructure.

Recommendation 10: MK Together should urgently seek to agree some meaningful key performance indicators [‘KPIs’] for actions arising from this review. Those KPIs should include both lead (predictive) and lag (hindsight) measures. Leading metrics are performance indicators that can be monitored now to help predict whether an organisation is likely to achieve its strategic aims. For example, if the strategic aim is to improve fire safety, a lead KPI might relate to using the data collected by fire services for HMICFRS returns to evidence that publicity around self-neglect and fire safety is resulting in an increase in referrals for HSFV from different partner agencies. A related lag measure would be the number of fire service call outs to the homes of adults who have a care and support plan. Similarly, if the strategic aim is to reduce the harm arising from alcohol misuse, lead KPIs may relate to the number of people referred to and accessing alcohol misuse services. A lag measure might be the number of admissions to local hospitals where the main reason was due to drinking alcohol.

Recommendation 11: Staff wellbeing should feature more prominently within operational priorities. Where an adult at risk dies, practitioners working with the adult should be offered opportunities to reflect or de-brief so that they are aware of additional processes, such as a SAR. They should also be advised of the outcome of any such processes and lessons for future practice. The Case review panel should amend it’s referral form to specifically ask what steps have already been taken to support practitioners working with the adult.

6. Glossary

ADASS	Association of Directors of Adult Social Services
ARC	Alcohol Recovery Community
BFRS	Buckinghamshire Fire and Rescue Service
BLMK ICB	Bedfordshire, Luton and Milton Keynes Integrated Care Board
CNWL	Central and North West London NHS Trust
CST	Community Support Team
ECHR	European Convention on Human Rights
HSFV	Home Safety Fire Visit
IARM	Interagency Risk Management Protocol
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983 (as amended)
SAR	Safeguarding Adult Review
SCAS	South Central Ambulance service
TVP	Thames Valley Police