Teeswide Safeguarding Adults Board
Learning from Regional and National SAR Cases

Title of Review:	**Anna 2020**
Theme of Review:	Mental health and substance misuse, and those whose capacity to make decisions is consequently affected by their dependency
Local Authority:	Leicestershire & Rutland
Date Published:	25/01/22
Link to Full Report:	https://lrsb.org.uk/uploads/sar-anna-overview-report-final.pdf?v=1643102048
Learning Briefing:	https://lrsb.org.uk/uploads/sar-7-minute-briefing-anna-2020.pdf?v=1643102065

Case Details:

Anna was in her fifties and had lived a life affected by abuse and neglect and possibly as a result became a substance misuser with associated brain damage. Anna had mobility problems, cirrhosis of the liver, inflamed pancreas, swollen abdomen and incontinence issues. Anna's relationships were dysfunctional and violent, and all of her children were removed from her care. Anna had history of mental health issues and in 2018 was detained for one month under Mental Health Act (MHA) due to presenting with delusional beliefs and the risk of self-neglect. Anna was later discharged into residential care but due to her drinking, staff found her behaviour unmanageable. Anna stayed a week in an alternative residential care home before staying with friends. She had no fixed abode until a suitable flat became available, her move was pending a package of care being in place. There was significant multi-agency involvement from 2017 until her death in 2020.

Anna did not manage well on her own, she struggled to oversee her finances, address her care and health needs and manage her alcohol misuse. Some neighbours reported Anna to the council for anti-social behaviour. An intensive support package was in place for Anna providing food parcels, shopping and medication, but Anna did not always engage and was sometimes abusive to carers.

Anna was subject to four safeguarding enquiries during the scoping period relating to alleged sexual assault, conduct of carers and medication and alcohol being stolen by people coming into her home. Anna refused to give details, so the outcomes were unsubstantiated.

Despite the intense support offered, Anna continued to struggle, and problems persisted with self-neglect and alcohol use. Anna continued to report issues about associates and disclosed that people were taking her medication and alcohol and assaulting her. Anna continued to insist on a home detox stating that she did not want to go to hospital. A Mental Capacity Act (MCA) assessment concluded it would be in Anna's best interest that she be removed from her home and placed in a hospital to undergo alcohol detox. An application was made to the Court of Protection (COP) who made an interim declaration that Anna lacked capacity in relation to where she should live, her care, her treatment, contact with others and her financial affairs.

Anna had two MCA assessments during the scoping period and professionals differed in their opinions.

In April 2020, Anna began refusing carers to the property. The fire brigade forced entry and Anna was found on the floor following a fall. Anna was taken to hospital where she sadly died.

Key Findings

- **Legal Literacy** - all agencies understanding the legal routes that can be used to safeguard people

- **Executive Capacity** - when assessing capacity under the MCA recognising that a person may demonstrate awareness into an issue in assessment and plan but not be able to execute the plan in the real-life situation.
- **Trauma** - agencies recognising and working effectively together to support people who have suffered childhood and ongoing trauma.
- **Assumptions** were made by agencies about Anna's 'chaotic' lifestyle which informed their responses and prevented them from understanding what life was like for her.
- Professionals must all agree the best **method of case communication** in complex cases
- **A practical response to a person suffering alcohol withdrawal, must be included within a multi-agency safety plan.**

Key Findings Relevant to the Teeswide Safeguarding Adults Board

The Learning Briefing suggests the following:

- *Consider your cases where there are complex needs and coexisting substance misuse and mental ill health.* (Assurance was sought from Carol SAR that mental health and alcohol services were working together in an optimum way to meet the needs of people with a dual diagnosis).
- *Has the multi-agency support team agreed the best way to communicate with each other?* (Multi-agency audits should highlight decisions around multi-agency communication).
- *Do you have the appropriate level of understanding in relation to Mental Capacity and Mental Health and substance misuse e.g. Executive functioning, use of IMCA and Advocacy? Do you know where to access this information?*
- *Is the care plan clear about managing alcohol intake?*
- *Has past trauma been acknowledged as part of the assessment and treatment plan?*

Can the learning from this SAR be incorporated into any work that falls from the Safeguarding Vulnerable Dependent Drinkers Report/Training? For example:

- How can we raise awareness of the short and long term impacts of substance misuse and withdrawal on mental capacity, including fluctuating and executive capacity?
- The report suggests that the multi-agency safety plan should include a practical response for a person suffering from alcohol withdrawal. Is there any existing information linked to this that could be shared?

This review found a lack of appropriate accommodation for Anna which caused delays in being able to move her from an abusive environment. As part of the Adult D LLR, Local Authorities considered adopting Middlesbrough Borough Council's *Provision of Accommodation for Homeless People with Mental Health Needs*. Are there suitable housing options for people in Anna's situation across Tees?

Do we need to raise more awareness or guidance around advocacy services?

Can we do anything further in relation to trauma informed practice and how this links to assessments and treatment plans?

Title of Review:	Evelyn
Theme of Review:	Regular moves between LA areas, LPA decision maker declining interventions on the person's behalf, neglect/coercive control, repeated hospital admissions, lack of professional curiosity and challenge.
Local Authority:	Richmond and Wandsworth
Date Published:	November 2021
Link to Full Report:	https://nationalnetwork.org.uk/Evelyn%20SAR%20Report%20v2%20Nov2021.pdf
Learning Briefing:	https://sabrichmondandwandsworth.org.uk/media/fdppsia4/7_minute_briefing_evelyn.pdf

Case details

Evelyn was a 75-year-old Black British/ African-Caribbean woman who was a retired midwife. Evelyn had physical and mental health needs. Evelyn had two sons, one of which (Simon) had a Lasting Power of Attorney (LPA) for Evelyn's care and welfare. Evelyn left the UK with Simon on 2nd March 2019 and died of a heart attack on 31st May 2019 in a care home in Jamaica.

Prior to this, Evelyn had been the subject of at least 34 safeguarding referrals, made to four London Boroughs over a 2-year period. Most of the safeguarding concerns highlighted that Evelyn was found confused and in a neglected state in, or away from her home. Contact with Simon at the time of these events suggested that he was distrustful of statutory services and was unwilling to facilitate medical or social care services for his mother. Despite this, Evelyn was left in his care.

Evelyn attended at least six hospitals but there was pattern of discharge against medical advice and of not being assisted by Simon to attend follow up appointments.

Evelyn's primary address was understood to be in Hillingdon, where she was ordinarily resident. However, she was known to live with her son Simon in Richmond. She also lived with her other son, Ted, in Enfield from time to time. Evelyn was moved from borough to borough regularly.

Care Act assessments were offered but were not made and it appears that professionals were often given enough assurance by Evelyn's family that her needs were being, or would be, met so that they withdrew. This was despite accumulating evidence to the contrary.

Key Findings

Repeated Hospital Admissions - Evelyn had attended hospital seven times in the last two months before she moved to Jamaica. This would seem to confirm that frequent, unplanned hospital admissions are a warning sign, although in Evelyn's case this pattern was perhaps less clear since she attended five different hospitals for different reasons.

Domestic Abuse, Coercion and Control - Domestic abuse is often considered in the context of intimate partner violence, but the Domestic Abuse Act is clear that its definition of being personally connected includes relatives.

Working with Family Carers - How Human Rights Act based approaches can be used to intervene in complex family situations, professionals need to consider how family relationships that contain elements of coercion and control, whether intended or not, can impact on the ability of family members to make decisions: despite asking for help when distressed, Evelyn seems to have then refused interventions or treatment, often when her sons were with her.

Professional Curiosity - There was insufficient engagement with Evelyn's family and there was insufficient professional curiosity or responsibility in exploring Evelyn's circumstances.

Cross-Borough Safeguarding Arrangements - Frequent moves made it difficult for professionals and there was insufficient inter-agency communication and joint working to meet Evelyn's needs.

Care Act Assessments - Assessments of Evelyn's needs were considered and offered, but these were refused on the basis that Evelyn did not need support or that her care needs were being met in other ways. There does not appear to have been consistent exploration of Evelyn's mental capacity to refuse an assessment and help or to consider whether or not her sons were acting in Evelyn's best interests.

MCA - It is clear that certain professionals recognised that the decisions made by Evelyn's sons were not always in her best interests and might cause Evelyn harm. Despite this, no action appears to have been taken to challenge Simon's Lasting Power of Attorney until 8th February 2019 when at the London Borough of Richmond's request, the London Borough of Hillingdon referred Simon to the Office of the Public Guardian in response to concerns that Simon was not using the LPA in Evelyn's best interests.

Key Findings relevant to the Teeswide Safeguarding Adults Board

Frequent attendances at hospital can be a warning sign that someone's situation is deteriorating, or their risk is escalating. Is the frequent attender system working effectively in Tees hospitals to spot patterns and trends? Do South Tees and North Tees hospitals have any arrangements in place to monitor frequent attenders that cross over to both service areas?

Could we include domestic abuse associated with relatives in any related awareness raising/comms work?

Have colleagues experienced similar cases where people with LPA may not be acting in the person's best interests? What options are available when this occurs? Could some practical advice/guidance around this be shared?

Have we got robust safeguarding/communication processes in place for individuals who may move frequently between LAs? What happens when someone is open to safeguarding and has moved but their whereabouts are unknown?