A report of learning concerning how services worked with Billy, with recommendations for partner agencies of the Bournemouth, Christchurch and Poole Safeguarding Adults Board, August 2023.

Billy

A Safeguarding Adult Review

For Bournemouth, Christchurch and Poole Safeguarding Adults Board, written by Professor Michael Preston-Shoot

Contents

"My brother was loved by us all, yes he made some questionable life choices but he was still human, he was still someone's family" (Billy's sisters)

Section 1: Introduction

1.1. Billy[1] died aged 47 in early July 2021 of natural causes. No inquest has been held into his death. Billy has been described by his sisters and his cousin as a "*likeable wee rogue*" and a "*cheeky chappy*" who was adored by his family, especially his nieces and nephew. His nephew is the "*double of his uncle Billy*." Billy "*absolutely adored*" his three sisters and "*was extremely protective*" of them. He never forgot birthdays and anniversaries. "*We just want you to understand the depth of love between us*." He was the "*double of his father*" who was run over as a pedestrian when Billy was very young. His sisters described that they had very similar traits and that Billy was their "*last link*" to their/his father. He had been "*very close*" to his father. He also lost his best friend on the same stretch of road about a year after his father's death.

1.2. Billy's mother remarried and Billy's family grew with the addition of two sisters. His three sisters and cousin have all described a close family. Billy was "*close*" to all his family. Although something of a "*rebel*" his relationship with his step-father was "*not bad*". When he moved away, he kept in contact with his mother, remaining "*close*", and towards the end of his life talked about returning home, to Scotland, where all his family continue to reside. This plan was interrupted by the Covid-19 pandemic and his poor health.

1.3. Billy's sisters and cousin described how he drifted into "*minor trouble*" and was "*a sheep, easily led*." He had what they described as a "*colourful youth*", never hurting anyone but "*dabbling*" in drugs, sometimes "*heavily*", and spending time "*inside*" as a consequence of stealing to feed his habit. It seemed that it was "*him against the world*." His sisters remained "*in constant touch*" with Billy, using FaceTime, letters and texts. Billy "*loved writing*."

1.4. Billy's family described him as "*strong-willed*" and as someone who could be "*his own worst enemy at times*." Even when he was struggling, he "*did not want people to look after him*" and he could be "*stubborn*." "*He would not back down*" and could "*put on a good front.*" He could be "*single-minded and determined*." He had "*issues*" keeping jobs. For a time he had been in the army but lost interest after he broke his leg/ankle. He never really talked about relationships and "*kept himself to himself*." He "*struggled to make relationships*" and "*did not trust easily*."

1.5. Family members were aware that he had "*medical issues*" but have been surprised by "*how bad he got*." They knew that he could be "*lax*" with managing his diabetes, that he struggled with this condition, and that he would not ask for help easily. "*He would not let people in*." He was "*independent*" but he would not have made himself unwell. His sisters in particular knew that he experienced "*mobility issues*" after an amputation and that he found it hard with his prosthetic leg. They felt that his drug misuse and his diabetes affected his body, and that he was neglected.

1.6. **Commentary:** the independent reviewer is very grateful to Billy's sisters and cousin who have provided such a rich and personal insight into who Billy was. All the family continue to experience raw grief and his sisters has described the whole experience as "*horrific*." Their further observations about how services worked with Billy are integrated into the remainder of this report. The family hope that lessons will be learned; knowing this might help them to achieve some form of closure.

[1] Billy's family relatives have requested that the SAR uses this abbreviation of his given name.

1.7. A referral for this Safeguarding Adult Review (SAR) was sent to the Bournemouth, Christchurch and Poole Safeguarding Adults Board (BCPSAB) on 26th January 2022 by the Head of Statutory Services, Adult Social Care (ASC) in Bournemouth, Christchurch and Poole (BCP) Council. The referral outlined that Billy had been "*living on his own in a flat with a commissioned package of care from BCP Council for 30 minutes support daily. A new care provider had been providing support to him since he moved to a new address in early March 2021."* He was described as experiencing "*poorly controlled diabetes mellitus and was on insulin, had hepatitis C, history of drug addiction- on Methadone, below knee amputation, perineal abscess, recent history of depression and suicidal ideation."* He was further described as having *"a long history of non-engagement with health and social care which is evidenced within GP records, hospital records, carer notes and ASC case notes ...* [and] *ongoing difficulties with his health including management of his diabetes and a poorly controlled diet leading to hospital admissions."*

1.8. The SAR referral highlighted that, when living in his previous accommodation between February 2019 and March 2021, concerns had been expressed "*regarding his poor health, unstable diabetes, poor mental health, suicidal ideation, choosing not to accept health advice and support … when very unwell. He often declined social care support, had a history of falls and a history of drug and alcohol use."* The SAR referral observed that Billy "*rarely allowed carers to support him*" and would sometimes deny them entry.

1.9. On the day before Billy died, when he was admitted to hospital for the final time, the care agency referred an adult safeguarding concern to the local authority[2]. An adult safeguarding enquiry[3] had been undertaken into the circumstances surrounding this final hospital admission and had concluded that:

1.9.1. There was confusion when the care agency contacted the emergency services over which service would respond to the request for a welfare check.

1.9.2. Billy's medical history was not explored by call handlers. Curiosity arose over whether the ambulance service might have responded differently if his diabetes history had been known.

1.9.3. There appeared to be a multi-agency failing to prevent self-neglect and subsequent death, dating back several years. There was no evidence of a multi-agency risk management (MARM) process or self-neglect and hoarding panel approach being considered.

1.9.4. Billy was known to several agencies and it appeared that there were limited risk assessments undertaken; those that have been seen appeared to have focused only on the issue raised at that time, other issues such as how to manage or support Billy's mental well- being appeared not to be addressed.

1.9.5. The care agency had not alerted ASC when earlier care visits had failed to see Billy.

1.10. BCPSAB concluded that the mandatory criteria for a SAR had been met[4], namely that an adult with care and support needs had died as a result of abuse and neglect (self-neglect) and that there was concern about how services had worked together to prevent and/or safeguard the person from that abuse or neglect (self-neglect). It was agreed that the agencies involved would each provide a detailed chronology and independent management report (IMR) with

[2] Section 42(1) Care Act 2014.
[3] Section 42(2) Care Act 2014.
[4] Section 44 (1-3) Care Act 2014.

critical analysis on how services had worked with Billy and with each other between January 2019 and August 2021.

1.11. The following key lines of enquiry were set for the SAR:

1.11.1. What planning and transition work took place with Billy to support him when he moved?
1.11.2. Given Billy had been previously detained under section 2 of the Mental Health Act 1983, what actions were taken following this to support him to move back home and live safely?
1.11.3. Given Billy's complex history of risk and knowledge that stress triggers suicidal ideation, what safeguards were put in place to support him at this time?
1.11.4. Learning for all agencies around assessing risk and the use of multi-agency risk management procedures, specifically to examine practice in terms of risk assessment and the escalation of high risk cases.
1.11.5. Examining whether, given the concerns which professionals had about Billy's lack of engagement, a formal mental capacity act assessment was undertaken and if so what was the outcome and how did professionals follow up on this?
1.11.6. Was executive capacity considered? Was Billy able to weigh up and consider the risks of his decision-making around medication and poor engagement with professionals?
1.11.7. Analysis of self-neglect and actions to support minimising risk where Billy was considered to have capacity.
1.11.8. To consider the impact of Covid-19. Were agencies delivering physical contact? If not how was contact with Billy maintained and risks understood/managed?
1.11.9. Examine whether any safeguarding concerns had been referred and if so what was the response and what actions were taken following receipt of those concerns?
1.11.10. Analysis of communication between agencies.
1.11.11. Analysis of social work and health practitioner involvement and management.

1.12. The following agencies contributed to the review:

1.12.1. Adult Social Care
1.12.2. Commissioning Service for Drugs and Alcohol reporting on information for a Specialist Drug and Alcohol Service
1.12.3. Police
1.12.4. GP and Named GP for safeguarding
1.12.5. Integrated Care Board (ICB)
1.12.6. Healthcare Trust
1.12.7. Substance misuse service provider
1.12.8. Ambulance Service
1.12.9. Social Housing Association
1.12.10. Department for Work and Pensions
1.12.11. Home care provider

1.13. Family members accepted an invitation to contribute to the review and their observations have been embedded throughout the SAR.

1.14. A learning event was held, attended by over 150 practitioners, operational managers and senior leaders, some of whom had direct contact with Billy. Feedback from the learning event has been embedded in the report.

1.15. **Commentary:** the independent reviewer is grateful for the candid analysis contained in all the chronologies and independent management reports that were submitted by the agencies involved. This has made the task of analysis, of understanding what happened and of answering the question “why?” much easier. The independent reviewer also acknowledges the reflective contributions that were offered during the learning event, and the determination of everyone present that lessons will be learned.

Section 2: Evidence-Base

2.1. The evidence-base is drawn from research and findings from SARs[5] that enable a model of good practice to be constructed in relation to adults who self-neglect. This model enables a whole system exploration of what facilitates good practice and what act as barriers to good practice. It comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect.

2.2. It is recommended that direct practice with the adult is characterised by the following:

2.2.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes; work to build motivation with a focus on a person's fluctuating and conflicting hopes, fears and beliefs, and the barriers to change[6];

2.2.2. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills; early and sustained intervention includes supporting people to engage with services, assertive outreach and maximising the opportunities that encounter brings[7];

2.2.3. When faced with service refusal, there should be a full exploration of what might appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; failing to explore "choices" prevents deeper analysis; contact should be maintained rather than the case closed so that trust can be built up;

2.2.4. It is helpful to build up a picture of the person's history, and to address this "backstory"[8], which may include recognition of and work to address issues of loss and trauma in a person's life experience that can underlie refusals to engage or manifest themselves in repetitive patterns;

2.2.5. Comprehensive risk assessments are advised, especially in situations of service refusal and/or non-engagement, using recognised indicators to focus work on prevention and mitigation[9];

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[5] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

[6] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[7] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[8] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[9] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

2.2.6. Where possible involvement of family and friends in assessments and care planning[10] but also, where appropriate, exploration of family dynamics, including the cared-for and care-giver relationship;
2.2.7. Thorough mental health and mental capacity assessments, which include consideration of executive capacity; assumptions should not be made about people's capacity to be in control of their own care and support[11];
2.2.8. Careful preparation at the point of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning;
2.2.9. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;
2.2.10. Thorough assessments, care plans and regular reviews, comprehensive enquiries into a person's rehabilitation, resettlement and support needs[12]; taking into account the negative effect of social isolation and housing status on wellbeing[13].

2.3. It is recommended that the work of the team around the adult should comprise:

2.3.1. Inter-agency communication and collaboration, working together[14], coordinated by a lead agency and key worker in the community[15] to act as the continuity and coordinator of contact, with named people to whom referrals can be made[16]; the emphasis is on integrated, whole system working, linking services to meet people's complex needs[17];
2.3.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;
2.3.3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;
2.3.4. Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequently implement planning and review outcomes[18];
2.3.5. Use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs associated with multiple exclusion homelessness, with specific pathways for

[10] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.
[11] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.
[12] Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.
[13] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.
[14] Parry, I. (2014) 'Adult serious case reviews: lessons for housing providers.' *Journal of Social Welfare and Family Law*, 36 (2), 168-189. Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.
[15] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.
[16] Parry, I (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.
[17] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.
[18] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital[19];

2.3.6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;

2.3.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;

2.3.8. Clear, up-to-date[20] and thorough recording of assessments, reviews and decision-making; recording should include details of unmet needs[21].

2.4. It is recommended that the organisations around the team provide:

2.4.1. Supervision and support that promote reflection and critical analysis of the approach being taken to the case, especially when working with people who are hard to engage, resistant and sometimes hostile;

2.4.2. Access to specialist legal, mental capacity, mental health and safeguarding advice;

2.4.3. Case oversight, including comprehensive commissioning and contract monitoring of service providers;

2.4.4. Agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;

2.4.5. Attention to workforce development[22] and workplace issues, such as staffing levels, organisational cultures and thresholds.

2.5. SABs are advised to:

2.5.1. Ensure that multi-agency agreements are concluded and then implemented with respect to working with high risk individuals; this will include the operation of complex case or multi-agency panel arrangements, responding to anti-social behaviour, domestic abuse, offending (community safety) and vulnerability[23]; strategic agreements and leadership are necessary for the cultural and service changes required[24];

2.5.2. Develop, disseminate and audit the impact of policies and procedures regarding self-neglect;

2.5.3. Include social housing providers in multi-agency policies and procedures[25];

2.5.4. Establish systems to review the deaths of homeless people and/or as a result of alcohol/drug misuse;

2.5.5. Work with Community Safety Partnerships, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate governance, namely oversight of the development and review of policies, procedures and practice;

2.5.6. Provide or arrange for the provision of workshops on practice and the management of practice with adults who self-neglect.

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[19] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE.

[20] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[21] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[22] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

[23] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[24] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[25] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

Section 3: Chronology Summary

3.1. Billy's sisters and cousin's contributions to understanding his backstory, his life journey, opened section one of this report. To this background can be added contributions from the agencies involved with Billy, which provide some background information and summaries of their more recent contact.

3.2. Billy first came to the notice of the police service in May 2010 when he was placed in a bail hostel in the Bournemouth area. He has a total of 20 previous convictions dating back to 1993, the last one being in 2011. He had warning signals for using drugs and is described on police systems as being an amputee (missing leg) and methadone dependent.

3.3. The GP contribution described Billy as an extremely vulnerable patient. He had been diabetic since childhood. He referenced childhood issues many times but had not disclosed what these were. He experienced frequent episodes of low mood and suicidal ideation. He was an intravenous drug user (IVDU) and was taking methadone but used alongside this. He lived in supported accommodation and had help with meals. However, this was felt to be inadequate for his needs and a contributing factor to his poor mental health. He appeared to want to remain well. He had a poor diet and poor control of his diabetes. He reported ongoing issues with pain and would self-medicate with drugs. He sometimes engaged and sometimes did not attend appointments, which made it difficult to monitor his health and wellbeing. He mainly engaged when he needed antibiotics or medications. He would usually want support with pain. There were concerns that he was diverting his medication which caused friction with practice. He was taken off pregabalin[26] for this reason.

3.4. Billy first became known to the local drug and alcohol treatment system for opiate substitution therapy (OST) in 2010 after a referral from prison. He engaged in treatment at various times up until 2014 when his case was closed as "*drug free*." Billy self-referred to treatment in April 2019 where he engaged up until his passing in 2021. There is reference in the notes from 2011 around trying to reconcile a relationship and in the Risk Action Plan from 2019 there is reference to a recent split with a partner and this ex-partner having children. The reasons why Billy began using drugs is unknown but the comprehensive assessment identifies illicit heroin use starting at age 19 (primary substance) and crack cocaine use starting at 17. Interventions focused on managing the prescribing of opiate substitute medication. There is no evidence in the notes from 2019 that portray insight into Billy's personal life or any aspirations he might have had around his journey of recovery relating to substance misuse other than being prescribed methadone. **Commentary:** here and elsewhere in this report is learning about practice needing to prioritise making safeguarding personal (MSP) and concerned curiosity.

3.5. Healthcare Community Trust records contained details of Billy's family history which his sisters and cousin also outlined in section one of this report. Billy never married and had no children. It is documented that Billy's mother was still his nearest relative under Section 26(1) (a) of the Mental Health Act 1983/2007. His medical history included the following: "*diabetes (type 2) with multiple complications; poorly controlled insulin dependent; peripheral neuropathy; diabetic retinopathy (poor attendance at clinics); left 2nd/3rd toe amputations and right 4th/5th toe*

[26] Used to treat epilepsy, neuropathic pain and general anxiety disorder.

amputations; deep vein thrombosis for which he was prescribed Apixaban[27]; previous intravenous drug use (on methadone)/long history of alcohol/substance misuse; hepatitis C; below knee, left leg amputation in February 2020; perianal abscess and necrotising fasciitis with colostomy (diagnosed with Fournier's Gangrene)."

3.6. Billy had previously been charged with burglary/theft and drug possession, and had spent up to 18 months in prison for street robbery – he was released in April 2010. Billy also had other spells in prison during the 1990's for burglary – this related to his addiction to heroin. His psychiatric history included an inpatient admission in 2002 to a hospital in Scotland following an overdose. He was known to mental health services in Dorset between 2010 and 2015, and was seen by liaison psychiatry in 2018 following an overdose of Pregabalin. This was in the context of a relapse in heroin use and pressures from people staying in/taking over his accommodation. This resolved and Billy was signposted to substance misuse services.

3.7. The housing provider contribution described Billy as someone who had *"a good sense of humour and enjoyed writing poetry and sharing this with the team. His main fears were around his overall health and this became more prevalent when his leg was amputated. At this point Billy lacked goals or ambition. His engagement with support lessened. People really had to build trust with Billy for him to accept the support. He often declined offers of support from all areas. For example, turning carers away, declining appointments and visits. However, when in crisis he would speak to the staff team."* The housing provider contribution added that: *"Although Billy had some anxieties around moving on, this was one of his main goals and he often expressed to staff his desire to move out of [the hostel]."*

3.8. Housing provider staff were aware of his support needs which focused around his tenancy and signposted him to additional services, such as drug and alcohol services for his use of Class A drugs. Billy had shared with housing provider staff that he had previously been in the army. He had described his early life as "*troubled*" but his family were really important to him. He spoke to them often and fondly and he often took phone calls from family members. Staff knew that Billy had a significant criminal history, but this had decreased prior to his time with this housing provider. He confirmed to staff that he was a heroin addict, but was open that he did not wish to stop. Billy could often be stubborn around accepting support and had felt let down by the system in the past. **Commentary:** the word "*stubborn*" was also used by his family and the housing provider contribution about Billy clearly aligns with what family members told the independent reviewer (section one above).

3.9. Adult Social Care (ASC) records date from 2018 and evidence that Billy had ongoing difficulties with his health including management of his diabetes and a poorly controlled diet leading to several hospital admissions. He was unemployed; however, he had in the past been in the armed forces. According to ASC records he experienced depression because of events in the past although this was not elaborated upon. **Commentary:** this is a significant omission, related to the importance of concerned curiosity, since a person's adverse life experiences might well illuminate or explain their substance misuse, suicidal ideation and mental distress.

3.10. In early May 2018 Billy was admitted to hospital with an abscess, which required debridement. He was referred by hospital ward staff to ASC for a care and support assessment. ASC staff saw

[27] An anticoagulant medication.

Billy on the ward on 21st May. Billy asked for information about how to move to more suitable accommodation as he was struggling with stairs. Advice was given. Home from Hospital support was also suggested to help Billy with personal care. He agreed to accept this help. He was given advice about Steps to Wellbeing because he stated that he was struggling mentally with things that had happened in the past. He was discharged with Home from Hospital short term support to help once a day with personal care. ASC closed Billy's case on 7th August having been advised that he was fully independent. **Commentary:** signposting is not necessarily effective. Accommodation issues were to become a repetitive theme. With a focus on prevention ASC staff might have worked together with housing to resolve his accommodation issues. Billy's mental wellbeing and substance misuse were also to become running threads. Again, with a focus on prevention, a fuller assessment of his health, care and support needs prior to, or soon after his discharge home, would have aspired to provide a wrap-around response.

3.11. In early November police officers recorded an incident at a hospital where Billy was receiving treatment and found to be in possession of a small amount of heroin (which was disposed of). At the time Billy was known to a targeted support worker who needed to be informed when he was being discharged from hospital as the locks on his accommodation had been changed following police intervention. The hospital social work team were not involved on this occasion.

2019

3.12. In January 2019 Billy was facing eviction from his accommodation. By February he had been housed initially in bed and breakfast accommodation prior to being accommodated by a housing provider in a project for single homeless people, including those with substance misuse and/or mental health problems. The suitability of this accommodation and the delay in finding a "move-on" option for Billy began to be raised as a concern later in the year.

3.13. There are references to suicidal ideation and Billy's low mood in January and November 2019. However, the focus throughout this year was predominantly on his physical health, most particularly control of his diabetes, wound care and pain management. Practitioners within primary care attempted to provide much of this healthcare throughout the year. However, sometimes when requested by Billy or when triggered by primary care clinicians, on five occasions in January, February and October ambulance service paramedics assessed Billy. On 6th January he attended an emergency department with chest pain and left leg swelling. He was diagnosed with DVT. On 18th January he attended an emergency department with an infected left leg. He was admitted and discharged on 12th February. On 19th February he attended an emergency department with left leg pain and difficulty weight bearing. He was discharged the same day. On 23rd February he attended an emergency department with diarrhoea and vomiting. He was admitted and discharged three days later. On 22nd October he attended an emergency department with an infected left toe, admitted and diagnosed with Ischaemic left 3rd toe, which was amputated. He was discharged from hospital on 31st October. He was reviewed by a diabetic nurse whilst an inpatient. It also appears that Billy attended hospital during May and was discharged with antibiotics.

3.14. Billy was referred to substance misuse services in April. He was assessed and attended a drop-in during May. There was some contact, mainly by telephone, with Billy in the final months of

the year. He was referred to ASC in January and again in February, the latter referral resulting in an assessment.

3.15. The Department for Work and Pensions (DWP) has confirmed that Billy was paid employment support allowance throughout except when the severe disablement premium was stopped on 26th July pending a tenancy agreement, on receipt of which all arrears were paid on 9th September. Billy had applied for personal independence payments (PIP) in 2018 but his application was disallowed in January 2019. Billy appealed and he was awarded the standard rate of daily living in March 2019 and the additional mobility component in July. Thereafter DWP has reported that there were no further disruptions or appeals regarding his welfare benefits.

2020

3.16. A recurring theme throughout this year was the appropriateness of Billy's accommodation. By February he had been a hostel resident for one year, when the usual length of stay averaged six months. Housing provider staff throughout the year expressed concerns, initially about the lack of a move-on option and adaptations to support his mobility in and around his accommodation. Subsequently, the concerns focused on the impact of his accommodation on Billy's mental health, and on staff feeling unable to meet his mental health needs and to manage his self-neglect. Billy was not regarded as in priority need by housing practitioners and towards the end of the year hostel staff began to explore private rental options. Occupational therapy assessment was delayed and then protracted because of the limited space in which Billy was living and the temporary nature of his accommodation.

3.17. Billy's mental wellbeing was once more in focus, with concerns about low mood and a psychiatrist opinion in November of "*significant depression*." At the end of June Billy was initially detained under section 5(2) Mental Health Act 1983 to prevent self-discharge from hospital. Following assessment he was then detained under section 2 Mental Health Act 1983 but discharged after a couple of days back to his hostel accommodation. There were two referrals, in late June and mid-December, for mental health support in the community.

3.18. However, Billy's mental wellbeing was overshadowed by ongoing concerns regarding his physical health. The concerns oscillated between difficulties managing his diabetes, including poor diet and loss of weight; wound care, pain management, and responses to abscesses and a below the left knee amputation (February). In July his health was described by a clinician as "*very poor*." Ambulance service paramedics attended Billy on twelve occasions throughout the year, not all of which resulted in hospital admission as Billy would sometimes refuse and was assessed as having capacity for decisions regarding his treatment. There were nine occasions when Billy was treated either in an emergency department or as an in-patient. In chronological sequence, Billy was treated for leg pain and non-healing leg ulcers, secondary to diabetes, with diagnoses of osteomyelitis and DVT, followed by an amputation described as "*a life-saving measure*." Subsequently, Billy was treated for post-amputation wound infection, vomiting and abdominal pain, and the consequences of poor oral intake. There followed treatment for perineal pain, abscess and necrotising fasciitis, leading to surgery for a colostomy and stoma left-side of the abdomen. Wound management and an attempted skin graft followed.

3.19. On at least four occasions during the year concerns were shared regarding Billy selling his medication. Substance misuse service practitioners had occasional, mainly telephone contact with Billy and routinely completed risk assessments. Billy continued to top-up his methadone prescription with use of Class A drugs. In late July Billy was reported to have no money.

3.20. Although he declined personal care, Billy did consent to a care and support assessment (March). This resulted in a package of care being commissioned, beginning in May. There had been difficulties finding a care provider agency to fulfil the terms of the care package. Thereafter, periodic concerns were expressed that Billy was not letting care staff into his accommodation. Two adult safeguarding concerns were referred to the local authority but neither resulted in an enquiry. Rather, the ASC locality team was informed of the expressed concerns. In the middle of the year there were referrals to the wheelchair service. Access to and movement around his accommodation was problematic and his wheelchair also appeared faulty. The impact on his mental wellbeing was observed. Backlogs meant a considerable delay in resolving this wheelchair issue.

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3.21. At the beginning of the year hostel staff were actively seeking more appropriate accommodation for Billy. He eventually moved into a one-bedroom flat in early March. He reported subsequently that this had a positive impact on his physical health and mental wellbeing. There were, however, reports of an infestation in the flat with, it appears, an expectation that Billy would address this himself. There was also some confusion between agencies as to his exact address.

3.22. As Billy had not engaged with community mental health support following a referral in December 2020, his case was closed. He self-reported an improvement in his mental wellbeing to GPs and substance misuse service staff.

3.23. The ambulance service chronology recorded two contacts with their paramedics, on 4th January when he declined transportation to hospital, and on 7th July when he was found to be "*very pale and emaciated*." A private paramedic provider call-out was also recorded in mid-March when he was reported to be safe and well. His only hospital admission occurred on 7th July when he was diagnosed with diabetes ketoacidosis. Billy died the following day.

3.24. Prior to his death Billy experienced ongoing pain, which he managed in consultation with his GPs. In March and April he attended appointments at a colorectal clinic for reversal of his colostomy. He self-reported that he was managing his diabetes better. He also attended a follow-up appointment with the urology clinic.

3.25. Substance misuse service staff maintained contact with Billy, mainly by telephone, but making contact could prove difficult. It appears that he was still using on top of his methadone in March but a drug test in June was clean.

3.26. A different care provider was commissioned when Billy moved as a result of a change of area. Both the first and the new care provider continued to report that Billy was either not contactable or refused to allow care staff into his flat. In May there were 15 occasions when

carer staff could not obtain entry. Up to 9th June 8 out of 9 visits had "*failed*." The ASC locality team was notified but his case remained unallocated. On several occasions the newly commissioned care provider reported that Billy had limited or no food in his flat. In late April there is a reference to Billy having no money. In April and May Billy was notified of a debt relating to the charge for his care package and he was adamant that he should not have to pay. This issue does not appear to have been resolved prior to his death.

3.27. Despite these concerns about self-neglect, and the difficulties of making contact with Billy, only one adult safeguarding referral was submitted, by the ambulance service following his final admission into hospital.

Section 4: Thematic Analysis

4.1. Several themes consistently emerge from the chronology, with important learning for practice and service improvement. This thematic analysis is organised around the domains of the evidence-base, the components of which were presented in section two of this review. The analysis draws on close reading of the chronologies and on the contributions from practitioners, operational managers and strategic leaders who attended the learning event.

Domain One: Direct work with individuals at risk

4.2. Engagement is a core component of the evidence-base. The introduction to the chronology from Billy's GPs summarises that "*he sometimes engaged and sometimes did not attend appointments*." He was described as "*unreliable*". *"He mainly engaged when he had a need [for] antibiotics or medications."* The introduction to the chronology from the substance misuse service concluded that Billy had engaged with the service between April 2019 and his death. The contribution from the second care provider agency records the number of times when Billy refused personal care or entry to his accommodation, when Billy requested shopping and when he declined referral to his GP.

4.3. The introduction to the chronology from Healthcare Community Trust also summarised his engagement. During 2019 Billy did not attend primary care appointments for wound management on 11 occasions but did attend 7 times, walking out once. He attended the DVT clinic once but missed one appointment. The pattern with podiatry was similar. He attended the diabetic foot clinic once but missed 6 appointments. He did not attend his one appointment with the ophthalmology clinic and missed two appointments for diabetic eye screening. During 2020 Billy did not attend two appointments at a leg ulcer clinic and he was discharged back to his GP. With podiatry, he attended on 6 occasions but missed three appointments and was again discharged back to his GP. He did not attend three appointments at a diabetic foot clinic but did attend twice at a prosthetic clinic and once each for diabetic eye screening and for diabetic eye laser treatment. In 2021 he attended the diabetic eye laser clinic once and podiatry on 4 occasions. He missed 5 appointments for diabetic eye screening.

4.4. The introduction to the ambulance service chronology points out that Billy *"accepted assessments and engaged in clinicians' questions but would often describe how he did not want to attend hospital and would not want to engage or allow domiciliary care staff or district nursing staff to help him … This, in addition to reported regular non-compliance with his medication led to a deterioration in his condition. As a result, many of his presentations were related to poor diabetic control, nauseated/vomiting with general malaise and numerous peripheral wounds, DVTs and leg ulcers.*" Indeed, shortly after the commencement of a care package in May 2020 care provider staff began to report that Billy was not letting them in and/or refused their assistance with activities of daily living. The housing provider description of Billy (see section 3) also records his variable engagement with the support that was being offered. **Commentary:** the chronologies do not indicate that there was a plan to resolve his variable engagement apart from monitoring.

4.5. In July 2020 there is reference to a GP conducting a home visit, which was good practice. Otherwise there does not appear to have been significant outreach, even allowing for the impact

of the Covid-19 pandemic, for example by substance misuse or mental health staff. Importantly also the chronologies are silent regarding any attempts to establish whether Billy was unwilling to engage with appointments and treatment or was unable, because of his physical disabilities and ill-health, and/or his low mood or depression. As the chronologies also reveal, during 2020 his wheelchair does not seem to have been fit for purpose. Nonetheless, assumptions were made, for example on occasions by district nurses, that Billy had sufficient mobility to attend his GP surgery for appointments.

4.6. At the learning event, staff recognised that Billy had not found it easy to engage and that his attitude that there was "*no point*" was taken at face value rather than explored. It was suggested that there might have been something akin to a self-fulfilling prophecy, namely that Billy was expected to disengage. There was no sense of motivational interviewing having been used, despite the evidence of its efficacy as a standard intervention in substance misuse services. As was pointed out at the learning event, "*the aim of the motivational interviewing approach is to target ambivalence to change, so [we could have explored with] Billy his ambivalence to obtaining help and support whilst his physical and psychological condition deteriorated."* Paramedics reported that Billy had said that much of the contact and advice to be taken to hospital felt "*pointless*" to him because it did not result in long term change. This sense of hopelessness mirrors that reported by some of the staff who worked with Billy.

4.7. Also at the learning event was recognition that it might be services that do not engage. One view expressed was that "*mental health services will not engage with individuals with active substance misuse concerns, but substance misuse services (usually only 3rd sector) continually refer to the fact mental health support is required. The person can then be left without support from either*." Another comment was that "*A lot of services are reliant on client engagement yet many of our clients are unwilling or unable to, which then results in services closing referrals and often social care or primary care being the only agency involved on the basis of vulnerability*." Another participant questioned whether there was an element of unconscious bias. They noted that self-neglect was often stated to be a lifestyle choice and that non-engagement then resulted in no further action.

4.8. A strong theme to emerge from the learning event was the importance of embedding a consistent trauma-informed approach when considering engagement. It was observed that "*there is no service for complex trauma in this area*." Those involved with Billy did not know his whole story and his reluctance to trust might have been the outcome of his lived experience. These reflections reinforced the importance of practice being trauma-informed.

4.9. Concluding the theme of engagement, one summary that was offered suggested that "*all our agencies have pockets of really good practice of working with individuals where there are challenges around engagement but this is not consistent across the board yet or adopted in generic services. We also are limited by capacity and only think outside the box in crisis.*" It was also observed that it is "*easier to close the referral when people don't engage, so you can move on to the next case (as there are waiting list pressures); that's the reality at the front door [and we] need a strategy we all adhere to*."

4.10. <u>Concerned curiosity</u> is a core component of the evidence-base. From February 2019 the chronologies highlight that Billy sometimes refused transportation and/or admission to hospital when he was "seriously unwell" but there is no indication that there was any concerned curiosity

exploration as to why. The personal descriptions of Billy provided by the services involved (section 3) offer glimpses into possible reasons but nothing more by way of elaboration. Nor does there appear to have been any expressed concerned curiosity regarding the appointments that Billy did not attend. This omission is explicitly addressed in the commentary on the substance misuse service's chronology, as follows: *"He had been sign posted to … to undertake urine screening but had been unable to get there due to having mobility issues … It is not stated what the mobility issues were on this occasion. Should the ability to attend appointments have been assessed due to his physical ailments?"* Instead there was a tendency to discharge Billy back to his GP. **Commentary:** whilst case closure might be an understandable response when demand on service is high, it is not an appropriate response without investigation in a context where there are known significant risks.

4.11. Similarly, opportunities to express concerned curiosity about the impact of Billy's life experiences were missed. In the context of Billy's fluctuating suicidal ideation and mental health in August/September 2019, the substance misuse service commentary asks: *"Could the key worker have asked questions about [Billy's] support network – important individuals in his life who could offer emotional and practical support, such as accompanying him to his appointments to help with mobility issues?"* There is evidence that later that year Billy referred to adverse childhood experiences in relation to his mental health. His GP knew that he was struggling to cope with childhood memories. This opening does not appear to have been followed up.

4.12. Again, in late June 2020 Billy offered a glimpse into his past. One healthcare chronology reports that Billy wished to self-discharge from hospital and was presenting as tearful/distressed and voicing thoughts of suicide. He is recorded as expressing that "*his past has come flooding back, not able to suppress further, can't carry on living the way that he is*." If that opening was followed up with concerned curiosity, it has not been recorded.

4.13. The Healthcare Community Trust and ambulance service chronologies provide one glimpse into Billy's reasoning for refusing hospital treatment, namely that he felt that whenever he attended hospital, IV access was attempted which usually failed, leaving him feeling that the process was pointless. **Commentary:** a variety of emotions often lie behind apparent refusals to engage, including shame, anxiety, embarrassment and fear. There were missed opportunities to explore his mental wellbeing, both when he was reporting "significant depression" but refusing to engage with community mental health services (November 2020), and when he stated that his mood had improved (March 2021).

4.14. At the learning event it was recognised that some staff did establish relationships of trust with Billy and could have built on those foundations. However, as will be seen later in the analysis of organisational support (domain three), high workloads and lack of time were felt to be barriers to both outreach and expression of concerned curiosity. As already reported, some staff believed that Billy thought engagement was pointless as he doubted that life would improve for him. This was mirrored then by some staff also feeling a sense of hopelessness. Paramedics shared an observation that Billy appeared very reluctant to be transported to a particular hospital. On these occasions he was assessed as having capacity for that decision but what might have lain behind his refusal to be conveyed does not appear to have been explored. **Commentary:** there might be a myriad of reasons why concerned curiosity is placed in the too difficult box. A sustained supervision and training focus on concerned curiosity would be appropriate.

4.15. Comprehensive assessments, regularly reviewed and refreshed, are a core component of the evidence base. Risk assessments were completed by substance misuse service staff on 12 occasions between April 2019 and May 2021. The assessments focused on risk to self, risk of harm from others, risk to others and risks to children. Without exception, risks were recorded as low. Sometimes risk assessments were completed without Billy's input; at other times reliance was placed on his self-assessment, for example that his mental health had improved after his move out of the hostel in March 2021 rather than triangulating what he reported with what else was known across the services involved with Billy. This is another example of an omission relating to concerned curiosity.

4.16. The commentary embedded within the substance misuse service chronology, compiled by commissioners for drug and alcohol provision, offers a detailed critique of these risk assessments. The critique includes the absence of input from Billy to some of the assessments and lack of detail regarding how his contribution was obtained for some others. The commentary observes the apparent infrequent contact between Billy and his keyworker, which returns the thematic analysis to the concern about engagement (discussed above). The commentary observes that it is unclear how judgements about the level of risk were reached. It questions why no physical health concerns were highlighted as risks when he was in a wheelchair, diabetic, with numerous hospital admissions and recent gangrene, and had to use a catheter. It further suggests that there were occasions, for example in March 2021, when he should have been considered high risk. It notes also that judgements were not revised when new information was received. The commentary also critiques an omission, namely not updating the care plan around collection/delivery of medication in response to his deteriorating mobility, and the standard of recording. For example, the commentary notes the absence of actions in response to risk assessments. It is especially critical of a May 2019 risk assessment where sections were either left blank or were not checked for accuracy and were incorrect.

4.17. Throughout the time that Billy was resident at a hostel, his support worker routinely highlighted the inappropriateness of his accommodation and concerns about self-neglect. The housing provider reported that he was "*too high risk*" for the project, and staff did not feel suitably trained to support Billy as an amputee. Their long list of concerns included Billy's mobility, hygiene, suicidal ideation and drug use. From July 2020 onwards care provider staff reported difficulties in contacting Billy and/or in providing the care and support that had been commissioned. There were also two adult safeguarding concerns referred in February and April 2020, neither of which resulted in an enquiry but were referred to the ASC locality team. The ASC commentary observes that no risk assessment appears to have been conducted despite clear indications that Billy was at risk; he was self-neglecting, had suicidal thoughts, and was selling his medications for money or other drugs.

4.18. On 17th July 2020 a GP visited Billy at the housing provider's request following a period of time when he had been feeling unwell and vomiting. The GP advised that Billy's health was very poor and because of the readings obtained regarding his diabetes they would not be surprised if Billy passed away. Billy declined any medical help or welfare checks. Housing provider staff undertook welfare checks and called for an ambulance when he was unwell. The housing provider requested enhanced care for Billy because they felt unable to provide him with the level of support he needed. As ASC's own commentary observes, this was not the first time that risks to life had been notified arising from self-neglect and noncompliance with medication.

Commentary: Housing provider staff were left holding all the risk. Safeguarding concerns were not being addressed. As Billy's relatives have commented, he was entitled to a level of care that he did not receive. "*He was silly and stupid sometimes but he deserved better*." "*They knew he was struggling.*"

4.19. Throughout the period under review GP records contain details of information-sharing about risks regarding Billy's physical and mental health, and substance misuse. As the commentary embedded in the GP chronology identifies, there were occasions when these risks were well documented, explicitly discussed with Billy and/or when there were plans to monitor and review. However, identifying the theme of recording (see below), the records are not always clear whether and how specific risks were considered, especially relating to Billy's mental health. For example, in March 2019, the commentary on the GP chronology observes good clinical management of wound care and assessment of Billy's control of his diabetes. However, there is no reference to other risks, namely substance misuse or mental health. Similarly, it is unclear from GP records whether the frequency with which Billy missed appointments was discussed with him. As the commentary on the GP chronology observes, a high risk picture developed of poor diabetic control, alongside poor attendance for reviews and history of drug use. There were opportunities to address some of these concerns with him. Nonetheless, GPs supported the need for Billy to move to more suitable accommodation, responded to concerns raised by district nurses regarding wound care, and monitored his physical health through frequent telephone consultations.

4.20. The second care provider agency has recorded its risk assessment. This covered medication, environment, and eating and drinking. Thus, "*Medication risk assessment demonstrated occasional reminder for medication. Environment risk assessment showed low risk rating as no hazards identified apart from Billy smoking in the property. Smoke alarm fitted. Eating and drinking risk assessment showed care worker to assist to prepare meals and drinks if needed. Specific risk assessments showed Billy self-medicated with methadone to manage drug addiction. Billy was confident he could manage his skin integrity but care workers to keep under observation and report any and all concerns. Care workers to engage with Billy in conversation and companionship in relation to depression. Billy agreed not to smoke when care workers were present and was aware of risks of smoking and potential fire hazard. Billy manages Type 1 Diabetes through self-administered insulin injections. Care workers to carry out light domestic tasks and assist Billy, where time permits, with reasonable requests to keep his home tidy and free of potential safety hazards.*"

4.21. At the learning event, it was suggested that effective multi-agency meetings were those where there were open and frank conversations between services and with the person regarding risks. This did not happen with Billy. Billy should have been at the centre of discussions. A contrast was drawn by one practitioner who referred to a case that had remained open, due to the risks involved and recognition of the importance of relational continuity, rather than closed to review as with Billy. However, this was seen as an exception – staff were not being encouraged to work in this way (see analysis below in the domain of organisational support). Best practice was enabled when there was a multi-agency approach to sharing information about risk and planning to mitigate it. **Commentary:** there were organisations surrounding Billy but, as will be seen in the analysis of domain two, the team around the person, services often worked in silos.

4.22. Another assessment central to effective work with people who self-neglect is mental capacity. Consideration of Billy's mental capacity clearly features in the chronology supplied by the ambulance service. Paramedics attended Billy on 20 occasions[28] between January 2019 and his death. On 7 occasions Billy declined treatment and/or transfer to hospital and on 3 of these instances the chronology provides evidence of mental capacity assessment. The chronology for 21st January 2020 reads: *"[Billy] was fully alert, speaking in full sentences. He refused observations and informed the crew on arrival that he had already told the nurse that he did not wish to go to hospital and stated that when he attends hospital IV access is usually attempted and fails and he is discharged on oral antibiotics. He stated that he feels that the whole process is pointless and wastes everyone's time. Due to this logical reasoning and staff member … witnessing [Billy] retaining the significant amount of information given by the crew as to the risks of not attending, being able to weigh it up, repeat it and still make the decision to refuse admission, he was deemed to have capacity. It was also explained that he would lose the bed …, it is documented that [Billy] understood this. Crew attempted to reassure him but [Billy] was deemed to have capacity and understood the risk of refusing. The risk being losing his limb, infections, sepsis and ultimately death."*

4.23. The ambulance service commentary on the chronology for 3rd February 2020 reads: "*The crew documented fully the capacity assessment under refusal and [Billy] signed this. He was offered hospital admission multiple times but he refused each time, despite being made aware that it was in his best interest to attend and the likely consequences of declining the crew's advice. [Billy] was made aware that he was taking responsibility for his own actions. The crew were able to get consent to inform his GP and gave him worsening advice before he walked off. I consider that the crew demonstrated good practice and did everything they could to access the correct treatment for him."* A similar pattern occurred on 15th March 2020. **Commentary:** the chronology is silent on assessment of mental capacity on the other occasions when Billy declined paramedic advice and assistance. The ambulance service's own commentary on the chronology also identifies a concern relating to one episode. It reads: "*It does not appear that a safeguarding referral was considered for this incident, but this may have been considered an 'unwise decision' by the crew. The fine balance between unwise decisions and self-neglect is recognised by the Trust."* Principle three within the Mental Capacity Act 2005 is often misinterpreted as establishing someone's right to make unwise decisions. The omission in not referring an adult safeguarding concern on this occasion is discussed later in this report under safeguarding literacy.

4.24. Mental capacity is much less evident elsewhere in the chronologies provided by the services involved. Initial documentation collated for the decision to commission this SAR identified a concern that it appeared unclear when mental capacity was assessed and for what decision. The second care provider agency has observed that the care and support plan, which was provided, stated there was no reason to doubt mental capacity and that he had capacity to make informed decisions. **Commentary:** mental capacity is time and decision specific; blanket assumptions should not be made. There do appear to have been missed opportunities to assess mental capacity, for example by Billy's GP in January 2020 when he was refusing to consider admission or readmission to hospital. Again, in later February the GP chronology records a clinical meeting at which it was agreed that a mental capacity assessment was required but this does not seem to have been undertaken. More positively, the GP chronology records an in-person assessment

[28] A private provider is included once in this sequence.

in Billy's accommodation in July 2020 where the GP assessed him as having capacity to refuse hospital admission. By contrast the GP chronology records discussion in a virtual hub in January 2021 in which it was suggested that a reassessment of Billy's mental capacity might be necessary. No reassessment has been recorded.

4.25. The Healthcare Community Trust chronology records that Billy was deemed to have capacity at the end of June 2020 during a mental health assessment to determine whether he should be discharged from the formal section 2 Mental Health Act 1983 admission for assessment. The substance misuse service chronology refers to Billy having capacity in early July 2020 when participating in a review of his medication. In October 2020 when Billy was expressing a desire to discharge himself from hospital he was deemed to have capacity to take this decision.

4.26. The GP chronology and IMR summarises concern about mental capacity assessment as follows: *"Overall capacity in terms of lifestyle self-neglect and diabetes wasn't done. It was generally in response to certain decisions he had made, but he wasn't reviewed in a general manner. Executive capacity not considered."* Similarly, the substance misuse service chronology and IMR summarises concern as follows: *"There is no reference to a formal Mental Capacity Act assessment taking place within Billy's notes." "There is no reference to executive capacity being considered in the notes."* Similarly the Healthcare Community Trust chronology and IMR observes that: *"Professionals/agencies made assumptions on Billy's capacity to make decisions around self-neglect … Ongoing risk assessment, revisiting capacity, and documentation of all stages of the process is key."* The ASC commentary also reflects that Billy's mental capacity might have been affected by severe infections. It also observes that there were missed opportunities to assess his mental capacity, for example when he was proposing to cancel his package of care.

4.27. **Commentary:** the references to executive capacity draw attention to the requirement to assess whether prolonged substance misuse had resulted in alcohol and drug-related brain damage. Substance misuse was a significant feature. What is unclear from the chronologies is whether there was sufficient consideration of the impact of substance-dependence on mental capacity and whether there was also sufficient consideration of the impact on mental capacity of physical ill-health, for example Hepatitis C, and mental distress. There was no reference to executive functioning, the capacity to act, despite repeating patterns.

4.28. At the learning event, questions were asked about whether Billy did have the mental capacity to take particular decisions and whether more could be done to promote best practice with individuals who are assessed as having decisional capacity but who remain at significant risk. Some participants felt that leadership from statutory partners, for example the ICB, would be helpful "*on cognitive impairment across the health and social care system so that all services / agencies are working the same way and have pathways and services in place once someone has been identified with a need or risk*." The theme of executive functioning was also commented upon, with participants observing that increased knowledge of how the frontal lobe of the brain can be impacted by trauma, substance misuse and adverse experiences would be helpful, alongside guidance on how to focus on executive functioning in mental capacity assessments.

4.29. Two additional barriers were identified in terms of mental capacity assessment practice, namely the pressure of time and misunderstanding of the five principles in the Mental Capacity Act 2005. Thus: "*In my experience of highly complex cases, many health and social care staff don't take the complexities into account in doing their capacity assessments! Many just interpret*

what is being said in front of them. Step 2 in the MCA 2005 is about taking reasonable steps when doing your assessment. That could include talking to other people involved in the case about the complexities, health needs, disabilities if appropriate, communication needs (especially neuro-divergent people), substance misuse factors, etc. We do indeed need a total re-thinking and overhaul of how capacity assessments are carried out, involving training from specialist practitioners and lawyers who are MCA specialists. I would like to talk to [practitioners and clinicians] about these issues but when is there ever the time to do that?" A link was made with concerned curiosity, namely the importance of seeking to understand a person's choices, to explore whether there was a clear rationale for their actions/inactions, especially in a context of repetitive patterns.

4.30. Mental health assessment and support is another core feature of the evidence-base. Throughout the period under review Billy experienced enduring forms of mental distress. Billy's family have expressed concerns about what they regard as a lack of involvement from mental health services when Billy was clearly "*struggling*." They have suggested that he would have benefitted from mental health support, especially to support his social wellbeing. "*He needed people to spend time with him, to get him out, to engage him in normal daily routines*."

4.31. Billy was signposted to a mental health support service in May 2018 when he reported that he was struggling with past memories. Suicidal ideation and risks associated with Billy's mental health are regular themes throughout the period under review, documented in GP records although, as the commentary on the GP chronology observes, documentation on the action taken in response is less clear. In November 2019, again as recorded in GP records, Billy was struggling with low mood, childhood memories and with coping with activities of daily living. No obvious follow-up has been recorded. In February 2020 housing provider staff were concerned about Billy's low mood following an amputation. In March 2020 they expressed concerns about Billy's mental health and suicidal ideation, and were advised by ASC to contact his GP. The housing provider contacted ASC again in April and May 2020 concerned about suicidal ideation. **Commentary:** signposting alone is often ineffective. ASC did not seek to refer Billy for a mental health assessment.

4.32. Hostel staff raised further concerns about Billy's mental health and suicidal ideation with ASC and his GP in May 2020. His GP and a practice nurse attempted to follow up, concluding that risk of suicide was low but that Billy was depressed. Medication was prescribed. In June 2020, whilst Billy was in hospital, an in-reach review of his mental health was completed by liaison psychiatry. He was initially detained under section 5(2) of the Mental Health Act 1983 pending full assessment. As detailed in the Healthcare Community Trust chronology, the outcome of the assessment was as follows: "*… threats of suicidality with imminent intent in a man with a complex mixture of physical and psychological stressors. Possible depression with re-activation of childhood trauma as well as adjustment reaction due to recent amputation. Presentation is also suspicious of possible underlying personality axis. Certainly, there appears to be current co-morbid substance misuse, the impact of which on his current presentation needs to be assessed. Due to the complexity of the above elements and the strong statements of the patient regarding imminent suicidal intent, assessing team feel that it is proportionate to detain under a Section 2 to facilitate a more accurate formulation and exploration as to if there are any needs that mental health services can assist with. He is expressing strong views that he will end his life as soon as possible. His risks are increased by non-engagement with medical and psychiatric services and with substance misuse.*" Detention under section 2 was lifted several days later in the

expectation that Billy's needs could be met by community services as the least restrictive alternative. **Commentary:** proportionality is a core principle within the administration of the Mental Health Act 1983 but there does not appear to have been a plan for community mental health follow-up and there was insufficient outreach to engage with Billy.

4.33. Indeed, the focus on Billy's mental health is not picked up again by chronologies until November 2020 when there was a further psychiatric review whilst Billy was in hospital. The Healthcare Community Trust chronology records that "*Billy had a significant depression and appears to have improved on Mirtazapine 30mg. [The] Consultant reported that Billy was not expressing any suicidal ideation, mood had improved. It was hard to predict his mental state soon after discharge. It was also noted that Billy had refused follow-up from Dorset mental health services several times but reported a good relationship with his GP and would accept weekly telephone calls in the short term to monitor his mental state. Consultant enquired whether it was possible for Billy's GP or suitable member of staff within the surgery to review Billy's mental state post discharge from hospital*." **Commentary:** Billy did not engage subsequently with community mental health services and was discharged. It is unclear whether any outreach was attempted.

4.34. Throughout the time that Billy was resident in a hostel, concerns about the impact on his mental health of accommodation inappropriate for his needs was expressed and recorded. Moreover, he reported that his mood lifted and his mental health improved when he moved out of the hostel. However, he continued to report that his mental health was variable.

4.35. The ASC commentary on the chronology suggests that there were missed opportunities to consider the use of guardianship (section 7 Mental Health Act 1983) which offers the power to require access to the patient to be given, at any place where the patient is residing, to any registered medical practitioner, approved mental health professional or other person so specified. It also suggests that there needs to be a better understanding of the impact of the loss of a limb and mental ill health on an individual. At the learning event it was observed that guardianship was little used and, perhaps, has been forgotten as an option, which might have been useful with Billy. Where guardianship had been used, practitioners had found it useful, especially for coordinating services around the person.

4.36. The substance misuse service commentary on its chronology observes that concerns about mental health and suicidal ideation were recorded but not included in an action or care plan. In some risk assessments, moreover, the section on mental health recorded that he did not have a mental health treatment need. It is critical of the apparent failure to explore suicidal ideation or to offer mental health support in-house or to refer Billy to other services. The commentary also poses several questions, namely: "*Could support for mental health have been explored? Could psychosocial one to one or group work been offered at the service as per the contract?*"

4.37. At the learning event it was suggested that "*there is very little mental health service for those with substance abuse issues. Our local CMHT is seriously understaffed and rejects most people who do not have psychotic illness. It is very hard to spend time looking for mental health issues that no-one will treat.*" This observation highlights concerns about resources, to which this report will return later in the analysis of organisational support for practice - domain three.

4.38. Care and support assessments are a further core component of the evidence-base on direct practice. In May 2018, whilst Billy was in hospital following amputation of some toes, he was assessed as requiring support with washing as he had difficulty standing. This support was provided until August. Billy was in hospital again in November 2018 but there was no referral to the hospital social work team. **Commentary:** this represents a missed opportunity to complete a section 9 Care Act 2014 assessment.

4.39. In January 2019 Billy was once again in hospital. A referral was made by a targeted support worker as Billy was facing eviction and considered vulnerable. The ASC commentary on its chronology observes that there does not appear to have been any follow up by the hospital social work team. There does not appear to have been any involvement from occupational therapy or the physiotherapy service. **Commentary:** this represents a further missed opportunity to assess Billy's needs for care and support.

4.40. On 15th February 2019 a housing provider staff member referred Billy to ASC. Billy had been placed in bed and breakfast accommodation. He had lost his scooter and so was unable to make trips to have his legs dressed. He had no funds and no cooking facilities. He was not taking his insulin. The housing provider staff member wished to know how quickly contact would be made as Billy was in "*a serious situation.*" The plan was to move Billy to temporary hostel accommodation. He would need a package of care but the housing provider staff member thought that he might refuse this. The ASC duty worker spoke with the district nursing team and asked for a weekend visit to administer insulin and to check on skin integrity.

4.41. Three days later an ASC duty worker visited Billy along with a housing provider worker. An assessment concluded that Billy did not require a package of personal care. The main issue was identified as his disability living allowance being changed over to a personal independence payment. His disability living allowance had been suspended so he could not afford his mobility scooter (which he was leasing on a monthly basis through his DLA mobility component.) If he had a scooter, he could live at a housing provider hostel where meals and drinks could be provided so Billy would be able to take his insulin at the appropriate times which would improve his sugar levels. Billy had stopped taking his antibiotics because he was getting severe diarrhoea from them so, because he was not taking these, his long-standing leg ulcers were not healing. **Commentary:** the ASC commentary on this part of the chronology has concluded that the assessment undertaken did not fully explore all the risks to Billy. No occupational therapy assessment was undertaken at this point and the ASC chronology falls silent until February 2020. The decision that Billy did not have care and support needs appears questionable. There are also duties to promote wellbeing and to prevent care and support needs arising. It is hard to see how these duties were met at this time.

4.42. Health and social care records note that Billy had a below the knee amputation in early February 2020. The ASC commentary on the chronology observes that occupational therapy assessment and a contact assessment were undertaken by the ASC Contact Centre. However, despite some risks being identified the assessment failed to adequately cover all the risks that had been raised by hostel staff. The focus was on Billy not being able to fully access the bathroom facilities at the hostel accommodation. This meant that Billy's risk of infection was increased because of the inability to wash himself adequately. Consideration could have been given to Billy accessing one of the day centres to utilise the disabled shower facilities. Although the local day centres had limited spaces due to the Covid-19 restrictions, he should have been

considered as a priority. **Commentary:** a fuller section 9 assessment does not appear to have been undertaken. Risk assessment is again a theme. At that time, due to the pandemic, occupational therapists were not always visiting to assess and provide equipment.

4.43. On 20th February a housing provider manager advised ASC that Billy had been living in hostel accommodation for a year when most people only stay 6 months. His leg had been amputated due to Billy not taking his insulin. The housing provider requested advice about alternative accommodation and/or adaptations. Billy was placed on the occupational therapy waiting list. On 3rd March housing provider staff expressed concern about Billy's current accommodation not being suitable for his needs. Following his left leg below knee amputation, his right leg was now infected. Housing provider staff felt unable to support Billy with his suicidal thoughts. He was not looking after himself correctly. The concern was passed to an ASC locality team. An ASC duty occupational therapist suggested that housing provider staff contact Billy's GP and Housing. **Commentary:** there is evidence of self-neglect but no section 9 assessment or section 42 enquiry is undertaken at this point. The ASC commentary observes that consideration could have been given to referring Billy for a Mental Health Act assessment.

4.44. On 16th March a housing provider manager again raised concerns with ASC. Billy had been acutely unwell and had also fallen. He was not taking his insulin correctly and his blood sugar levels had been dangerously high. He had refused admission to hospital. Housing provider staff were struggling to support Billy; he was also struggling with personal care. Billy needed equipment but ultimately required suitable accommodation. An urgent occupational therapy assessment was requested, in part to support an application for alternative accommodation. The same day a housing staff member contacted ASC for information about Billy's care needs, having received a homeless housing application. The advice given was that Billy was on an occupational therapy locality team waiting list. The following day the same housing staff member spoke to an ASC duty occupational therapist requesting a full Care Act assessment to assist in finding appropriate accommodation. The referral was passed to the ASC locality team.

4.45. On 20th March the housing provider contacted the ASC duty worker for the locality team increasingly concerned about Billy's welfare. District nurses had been unable to take bloods as Billy was dehydrated having not been taking fluids. The housing provider again requested urgent occupational therapy and care and support assessments but were advised that the ASC locality team was screening and prioritising referrals based on risk and that managers would decide which referrals were a priority for allocation. The ASC commentary expresses concern about the delay in responding to urgent requests for assessment.

4.46. On 31st March a social worker completed a phone assessment. Billy declined help with personal care. His room was recorded as needing a good clean; there was dried blood on the floor. An occupational therapy assessment was requested as Billy had fallen several times and needed equipment; he was using a wheel chair. This appears to have been deferred until occupational therapy input was required regarding re-housing issues. Billy stated that his main issue within the current property was the step to outside; he would benefit from having a wet room and was strip washing. Billy was currently having meal deliveries but stated he could heat up his own microwave meals if required. The ASC commentary commends this assessment as person-centred, fully involving Billy in agreeing a support plan to encourage him to wash and to seek assistance as required. Time permitting the plan included ensuring his room was clear of clutter and was as clean/tidy as possible. It appears that implementation of the care and support plan

was delayed due to the Covid-19 pandemic. On 5th May ASC received a request for an urgent care package. It was recorded that he had not had a shower since February. The care and support package began on 22nd May.

4.47. Subsequently the focus switched to how well Billy's care and support needs were met. There are several strands here. Firstly, issues arose in June 2020 regarding his wheelchair. His room was too small to ensure safe transfer to and from his wheelchair, and it also required either repair or replacement. The wheelchair service was asked to review but there appeared to be disagreement as to whether a GP referral was required. This issue continued into July when ASC were advised that a visit by staff from the wheelchair clinic could take weeks. In late August an ASC staff member was advised by the wheelchair clinic that Billy was on the waiting list but he could be waiting months as there was a large backlog. **Commentary:** there is no reference in any of the chronologies provided by the services involved that the wheelchair issue was resolved before Billy died. His care and support needs remained unmet in this respect.

4.48. Secondly, almost from the very beginning of the package of care, concerns were raised with ASC about Billy's refusals to allow carers into his accommodation and to provide the support that had been commissioned. The ASC commentary observes that these concerns were passed back to the housing provider and care agency to monitor and manage when in fact care provider staff might not have had the appropriate levels of training to be able to respond. It suggests that convening a multi-agency risk management meeting would have been more appropriate (as discussed later in this report) to share the burden of responsibility. At times there also appears to have been some disagreement about how often in the hostel Billy was refusing to allow the carers into his room. The ASC commentary on its chronology further records that In May 2021 Billy had refused the carers 15 times, and in June 2021 the carers had only managed to gain entry 5 times. The ASC locality team was alerted to the issues of Billy not letting the carers in and the concerns that they repeatedly raised. The ASC locality team operated a duty system that screened outstanding referrals and reviews. These were prioritised as high, medium or low; anyone considered to be high risk was contacted. Billy was not seen as a high priority as he had carers visiting and was being seen at times through a window. It appears that despite the concerns being raised these were seen in isolation. **Commentary:** this once again highlights the theme of risk assessment. A repetitive pattern, in a context of the health and social care history, is an indication of significant risk. ASC did not change its response to the concerns raised between June 2020 and Billy's death.

4.49. More positively, when Billy was in hospital his care package was protected and it resumed following his discharge without delay. However, the second care provider agency has criticised the care and support plan that was received, observing that it was inaccurate and out of date. The care provider agency has reported that its care plan was developed with Billy. Although a reminder to take medication was not commissioned, this was assessed by the [home care provider] as a basic level of person-centred care that would support Billy with his health. Medication risk assessment completed with Billy demonstrated Level 1 which means he remained accountable for his own medication with an occasional reminder. Although offering food and drink preparation was not commissioned, this was assessed as a basic level of person-centred care that would support Billy with his breakfast or other meal/snacks. He remained independent with his eating and drinking as the [home care provider] task list clearly stated. **Commentary:** there is good evidence here of making safeguarding personal but also concern about what had actually been commissioned. Thus, "*at no time were [home care provider staff]*

accountable for monitoring Billy's nutrition and hydration. Care workers often went over and above their remit by going shopping for Billy, when he requested this to purchase basic provisions such as bread and milk."

4.50. Thirdly, despite the unresolved issue with his wheelchair, the inappropriateness of his accommodation, continued evidence of self-neglect and the concerns that Billy was refusing to accept the support that had been commissioned, Billy's case was closed to review by ASC in early September 2020. His care package was to be reviewed in 6 months. **Commentary:** closing to review did not safeguard Billy, nor did it give sufficient attention to the duty to promote wellbeing and to prevent escalation of care and support needs. Returning to the theme of concerned curiosity, it does not appear that anyone in ASC attempted to explore with Billy his reluctance to accept care and support. The ASC commentary on its chronology observes that there is no evidence to suggest that when the care agency reported that they could not gain entry to Billy's flat, any consideration was given to the ASC Failure to Gain Entry Policy. Instead, it was recorded that the care agency was monitoring the situation; however, as they were not going into the property this calls into question how they were able to monitor the condition of the flat or Billy's wellbeing.

4.51. At the end of November 2020 the housing provider raised concerns about Billy's deteriorating health, non-compliance with medication to control his diabetes, suicidal ideation and self-neglect. The housing provider requested an urgent Care Act assessment but was advised that the concerns were health-related and should be referred to Billy's GP. At the beginning of December, when Billy had once again been in hospital, a review of his care package was requested but there was a waiting list. In early January 2021 the care agency advised that Billy was refusing entry to carers. Billy's case had not yet been reviewed. Further concerns were raised either by the housing provider or the care agency in January, February and March. The ASC commentary expresses concern that once again responsibility was passed back to the provider when this situation should have been identified as a priority for a review.

4.52. More positively, Billy's move in early March into his own accommodation did result in a telephone review of his care package and the commissioning of a new care agency due to the location of his flat. Floating support was provided by the housing provider to cover the gap left by the transfer of the care package. It appears that initially the new care provider might not have received the correct schedule for visits that had been agreed with Billy. There periodically followed concerns both about Billy having no food and looking malnourished, and refusing entry to carers. Carers also reported that they were unsure if Billy was washing or showering himself as they were meant to assist him on the care plan, but he wanted to do that himself. As Billy was frequently refusing entry, carers were unable to monitor whether he was well or if his property was deteriorating. The care agency believed an urgent review was required. The ASC commentary expresses concern that no action was taken by the ASC locality team. There was no allocated worker to be a point of contact for the care agency. This highlights the risk of a system that closes cases to review when there are significant ongoing concerns. The ASC locality team had a long waiting list but the ASC commentary concludes that, given the ongoing risks, Billy should have been a priority for allocation. This highlights a theme of resources, discussed further in the report below.

4.53. Billy's relatives have also expressed concern about the lack of responsiveness when carers could not obtain entry. Billy's relatives believe that Billy "*was let down*" both because carers did

not call back later or did not alert ASC on every occasion. They have pointed out that Billy was significantly disabled by his diabetes and might have been asleep when carers called. They have been particularly concerned at the lack of responsiveness to failed visits in the few days before Billy was admitted to hospital for the final time. They believe that there might have been a different outcome had Billy be found earlier.

4.54. Two further issues arose in the final months of Billy's life that would have merited a formal review of the care package. One related to infestation in Billy's new accommodation, the responsibility for which was left to Billy to resolve. The other related to charging for the care package. Initially invoices were addressed to the wrong flat. Once Billy received notification, he declined to pay and expressed a wish to cancel the care and support package. This remained an unresolved issue before Billy's death, partly because he had not been allocated a social worker. **Commentary:** there is no reference in the ASC chronology to the power to waive charges for domiciliary care. ASC does not have to charge for home care and should consider waiving charges where significant risks would arise if a package of support was not provided.

4.55. It was acknowledged at the learning event that there had been delays in ASC allocation due to operational pressures and that these pressures continue. Also acknowledged were the risks inherent in closing some cases pending review. It was suggested that those conducting assessments needed to think creatively, for example by having considered which staff member might have been best placed to engage Billy in assessment of his care and support needs, and to move away from a standard approach in cases similar to Billy's. A view was expressed that currently assessments do not encourage person-centred planning. The focus needed to be on wellbeing and prevention, not just on whether two or more eligible needs had been met. To promote this broader view of assessment, a strengths-based conversational approach should be promoted, beginning with what a person wants but adding in possibilities for discussion. The purpose here would include seeking to *"strengthen networks around [the person] and resources available to [them], including evolving or adapting what's already there or creating something new."*

4.56. Hospital discharge is an important transition and the focus in the evidence-base is therefore on the wrap-around health, housing and social care response in order to prevent an escalation of needs and risks. In total in the period under review Billy had 15 episodes of healthcare in an emergency department or hospital admission. How well services worked together when Billy was admitted to and discharged from hospital, and whether adult safeguarding concerns were recognised and referred, will be discussed in the next section of the report. Here the focus is on meeting Billy's needs.

4.57. In May 2018 Billy was in hospital due to a foot infection. Some of his toes were removed and his poor diet was noted. He was known to be an insulin dependent diabetic. He was signposted to housing rather than referred when he stated that he was finding the stairs in his accommodation difficult to manage. It was observed that he had another infection starting on his other foot and Billy accepted home from hospital support to control this. A further hospital admission in November 2018 does not appear to have concluded with specific discharge plans relating to health, housing or social care.

4.58. In February 2020 Billy had a below the left knee amputation. Whilst in hospital Billy was referred to the Intermediate Care Team. Billy was reluctant to engage with therapy and he

declined demonstrations of wheelchair transfers. The discharge plan was for district nurses to monitor the stump and diabetic ulcers on his right leg. Housing provider staff were expressing concerns about the length of time Billy had been living at the hostel, and about the suitability of that accommodation, but there does not appear to have been a concerted plan to address his accommodation needs at this point.

4.59. In June 2020 Billy was discharged from hospital back to hostel accommodation, having been detained under the Mental Health Act 1983. The discharge plan was a continuation of community-based treatment for his physical and mental health issues. The history of Billy's engagement does not appear to have prompted a review of the approach to meeting Billy's healthcare needs.

4.60. In October/November 2020 Billy was once again in hospital. His prosthetic leg was not fitting well due to swelling. He had been unable to get to a pharmacy to collect his methadone. He had declined referral for community mental health support but was expressing a willingness to accept daily support with personal care (previously the care package had been for three days each week). His mental health had improved following prescription of mirtazapine but clinicians were concerned about the impact of his hostel accommodation on his mental wellbeing. The hospital social work team requested consideration of re-housing and the possibility of an interim placement was raised. **Commentary:** prior to discharge there was no multi-agency risk assessment and no coordinated plan to address Billy's health, housing and social care needs. Services continued to respond individually. There does appear some evidence that Billy's self-neglect was seen as a lifestyle choice.

4.61. Despite repeated attendance at emergency departments and hospital admissions, once the acute nature of Billy's physical ill-health had been treated, Billy was discharged. At no time did the history of concerns regarding Billy's physical and mental health, his accommodation and his ability to manage activities of daily living, prompt a coordinated plan. What can be learned, therefore, about how his accommodation and healthcare needs were met (social care has been discussed above)?

4.62. Concerns were expressed about the suitability of Billy's accommodation in May 2018 and by January 2019 Billy was facing eviction. There does not appear to have been a referral to the local authority's housing department using the provisions of the Homeless Reduction Act 2017 at this point, or at any time subsequently. When Billy was admitted into a housing provider hostel there does not seem to have been a coordinated move-on plan at this point. Indeed, it appears that it was only in February 2020, when Billy had been living in the hostel for one year, that the housing provider began to raise concerns about the impact on Billy of his accommodation, in the context of his mental wellbeing and physical disabilities.

4.63. In April 2020 the ASC commentary on its chronology observes that there is evidence that the Housing Department advised that as Billy was not homeless or being threatened by homelessness he was not seen as a priority for rehousing and an occupational therapy report was declined. However, ASC had sufficient evidence to support his housing application and it appears that not all the concerns were shared with colleagues in Housing. **Commentary:** there is no evidence in the ASC chronology that, when Billy's care and support needs were assessed and a package of care commissioned, his accommodation needs were taken into account. Section 23 (Care Act 2014) seeks to clarify the boundary between care and support and housing legislation.

The statutory guidance[29] that accompanies the Act, particularly Chapter 15, provides further detail. The lack of suitable accommodation puts health and wellbeing at risk. Suitable accommodation is one way of meeting a person's care and support needs. However, where a local authority[30] is required to meet a person's accommodation needs under the Housing Act 1996, it must do so. Where housing is part of the solution to meet a person's care and support needs, or prevent them, then the care and support plan may include this, even though the housing element is provided under housing legislation. Any care and support required to supplement housing is covered by the Care Act 2014. Case law[31] has also established that a need for accommodation on its own is not a need for care and support and local authority adult social care departments must consider if care and support needs are accommodation related.
Commentary: further discussion of legal literacy follows later in the report.

4.64. In July 2020 residential care was discounted as an option as Billy was not thought to meet the criteria. At different points during 2020 occupational therapy assessments were either pending allocation or had concluded that equipment and adaptations could not be provided because of the nature of Billy's accommodation or because his housing application was pending. Transfers in his room and maintaining the cleanliness of his wounds remained challenging for Billy. An occupational therapist provided a report for housing colleagues and in November 2020 his GP also requested that his housing application be reconsidered because Billy's current accommodation was not suitable for a wheelchair user. However, his accommodation needs remained unmet until March 2021 when Billy moved into a flat, having been supported by the hostel housing provider to do so.

4.65. At the learning event there was much discussion about the need to embed a multi-agency (risk management) approach, and when Billy was approaching hospital discharge it would have been appropriate to convene the system in order to share information, and coordinate planning about meeting his needs and mitigating risks. It was suggested, particular in cases where there are repetitive patterns, that enhanced case management would be a useful approach, again with a focus on prevention and coordinating the input of different services and disciplines.

4.66. <u>Assessment and treatment – physical health and comorbidities</u>. Throughout the period under review Billy was known to substance misuse services. Learning from the twelve risk assessments completed between January 2019 and May 2021 was discussed earlier. Commentary within the information supplied by substance misuse commissioners and providers also notes the apparent absence of any offer of support regarding his mental health, and concern about an apparent failure on occasions to consider whether Billy was physically able to collect his methadone prescription. The final risk assessment in 2020 was not reviewed following further information that Billy appeared to be selling his medication.

4.67. The chronologies regarding substance misuse pick up Billy's engagement from mid-April 2019 when he self-referred for support with heroin use. He reported using £30-£40 of heroin per day and injecting into his thigh due to an abscess in his groin which he intended to seek medical attention for via A&E. Billy reported trying to smoke rather than inject.

[29] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.
[30] This will be the local housing authority, the lower tier authority in a two tier situation.
[31] R (SG) v Haringey LBC [2015] EWHC 2579 (Admin).

Harm minimisation advice was given. Billy was also using crack cocaine 2-3 times a week. Billy reported a DVT in his left leg, a varicose vein and being diabetic; having had parts of both feet removed due to diabetic ulcers. Billy reported he was having dressings every other day for this. Billy reported generalised anxiety disorder, depression and historic suicide attempts. He was currently feeling suicidal sporadically. Billy had a full assessment booked for the 23rd April which he attended. He was drug tested (saliva). All results were recorded as negative. The service's commentary observes that having the comprehensive assessment and appointment booked for the same time could be considered good practice in terms of service efficiency (avoids duplicating information) and streamlines the service for the service user. **Commentary:** here and in what follows there is no apparent attention to Billy's mental health or his ability to get to appointments, as the service's commentary itself acknowledges. On occasion, indeed, Billy referred to being unable to keep appointments because of mobility issues.

4.68. The plan seems to have focused on harm minimisation. There is little evidence of discussion around Billy's longer-term goals around drug use or his physical and psychological health. When he tested positive for opiates and cocaine use, as in late May 2019, advice regarding risks was given. When he missed appointments, for example in August 2019, letters were sent rather than outreach being attempted. This meant that he did not see his keyworker for several months.

4.69. The theme of concerned curiosity also emerges again here. In late May 2020 in a telephone call Billy denied feeling suicidal but did report fluctuating low mood following his amputation: "*of course I have low mood.*" He reported using on top of his script, 2 bags of heroin a day smoked. The substance misuse service's commentary observes that there was no contact with Billy subsequently to see if the methadone medication increase was keeping his 'on top' use reduced and check how he was feeling now his dose was higher. It could be considered good practice, however, to increase a prescription to a more therapeutic dose. When attempts were recorded to have failed to contact Billy by telephone, there is no evidence of follow-up attempts, as in June 2020 and February 2021. This meant quite long gaps between occasions when Billy was actually seen by substance misuse practitioners. When calls failed, the housing provider was not routinely contacted to check on Billy's welfare.

4.70. More positively there are recorded occasions when contact was made with Billy, for example in November 2020 to confirm arrangements for safe delivery of his prescriptions following hospital discharge and to offer advice about risks. In March 2021 in a telephone call with Billy, discussion took place about delivery of his prescriptions so that he did not have to miss hospital appointments. In late May 2021 a substance misuse worker visited Billy at home to carry out a drug test. This was good practice. Billy was also advised to attend all appointments, to advise of any difficulties in so doing, and to provide updates of any changes to medication prescribed by his GP, to avoid review of arrangements for receipt of his prescribed medication. **Commentary:** it was perhaps optimistic simply to expect Billy to follow advice, given the history of his involvement with service providers.

4.71. Throughout the period under review Billy's physical health was managed and reviewed by his GPs, practice nurses and district nurses. There was some focus also given to his mental wellbeing. The GP commentary observes, for example, a thorough review by a practice nurse of wound care, diabetes, weight loss and suicidal ideation. The Healthcare Community Trust chronology from February 2019 onwards records district nurses monitoring Billy's insulin intake

and checking his skin integrity. Billy was not always in when district nurses called and some assumptions were made that, as Billy was not housebound, he could attend surgery for wound care and did not require district nurses to treat him at his accommodation.

4.72. Nonetheless, district nurses and Billy's GP continued to review wound care and to treat with antibiotics when required. Diabetic blood tests were arranged and poor control documented. The GP commentary for the end of March 2019 observes that clinical management and assessment of diabetic control were good. His erratic attendance complicated clinical management and the GP commentary observes that this might have been discussed with him. By mid-May 2019 it suggests that a high risk picture was developing of poor diabetic control, alongside poor attendance for reviews and history of drug use. This could have been a good opportunity to address some of these concerns with him.

4.73. On 23rd May 2019 Billy's GP responded quickly to notification of a hospital discharge. The GP commentary observes good practice in booking a follow-up call and bringing Billy in for a face to face appointment after vomiting was heard during the call. The GP also made appropriate urgent referrals to a diabetic foot clinic in July 2019 and to a leg ulcer service in August. In mid-September the Healthcare Community Trust chronology records the GP sending an urgent diabetic foot management referral. **Commentary:** the appointments offered were sometimes several months later.

4.74. In November 2019 the GP commentary records appropriate management and follow up of wound care following a hospital admission during which some toes were amputated and his diabetic treatment changed. In mid-November, however, when Billy was clearly struggling with low mood as a result of childhood memories, and when his blood sugars were high but he had refused hospital admission, follow-up was less immediate.

4.75. Towards the end of January 2020 district nurses, paramedics and Billy's GP all advised hospital admission, which Billy declined, in response to pain, and wound infection. It appears that Billy was using heroin for pain relief. He eventually agreed to admission at the beginning of February, during which he had a partial leg amputation. After discharge district nurses resumed home visits and his GP undertook telephone and face-to-face consultations during which Billy reported low mood, using heroin in addition to methadone, and phantom leg pain. The treatment objective was to attempt to improve Billy's control of his diabetes. District nurse visits continued, responding flexibly when a fall aggravated his wounds.

4.76. At the beginning of April the GP and practice nurse treated a groin abscess but did not contact substance misuse services with this information. His medication was reviewed at the end of April. Ongoing pain in his amputated leg resulted in medication change and referral to a pain clinic on 6th May. The GP and Healthcare Community Trust chronologies record attempts by his GP and a practice nurse at the end of May to discuss with Billy his mental health, resulting in further modification of medication.

4.77. On 14th June Billy called 111 and an out of hours GP visited. Concerned about possible ketoacidosis, Billy was admitted to hospital and discharged on 1st July 2020. District nursing visits resumed, observing drug paraphernalia and lost weight, and providing advice about diabetic management. District nurses expressed concern about his diet and Billy sometimes refused to allow his skin to be inspected. District nurses appropriately shared concern with Billy's

GP who responded with a home visit. This resulted in a further hospital admission after Billy had initially refused. The GP's assessment was that his health was extremely poor. **Commentary:** there is a repeating pattern of concern about Billy's physical health, with known risks. Billy's response oscillated between refusing medical and welfare checks and agreeing to treatment, including hospital admissions. The pattern continued and did not prompt a whole system review of the approach being adopted, or referral of an adult safeguarding concern.

4.78. District nurse monitoring of his skin integrity continued when Billy was not in hospital, with Billy's GP adjusting his medication when required. For example, on 2nd September Billy's GP undertook a home visit and documented high risk due to diabetes. Antibiotics were prescribed due to an abscess on his left buttock. The GP commentary notes the absence of any documented discussion regarding whether admission was required/considered given the history of diabetes and infections. He was admitted several days later. District nurse visits resumed from early November and the GP had follow-up calls with Billy who would usually state that he was managing okay. **Commentary:** a hospital consultant had advised more intervention in the community. However, the pattern continued much as before. Concerns raised by district nurses regarding wound care were responded to with antibiotics. The GP commentary observes that there was regular monitoring of a patient known as high risk. A diabetic nurse review was booked. Billy's relationship with his GP appears also to have deteriorated because his pregabalin medication had been stopped.

4.79. In later November Billy complained of pain around his supra-pubic catheter site. A urology follow-up appointment had been arranged. He experienced another fall and concerns resurfaced regarding suicidal intent. Between 1st and 4th December Billy was in hospital for vomiting. Blood sugar levels wouldn't stabilise. District nurse visits resumed and his GP made an urgent referral to community mental health, with which Billy did not subsequently engage. On 23rd December a planned admission to hospital occurred to remove the supra pubic catheter. Billy was discharged the same day. District nurse visits continued.

4.80. On 7th January 2021 the GP chronology records a telephone consultation with Billy who complained that his pregabalin had been stopped by his previous GP. He complained of leg pain. He declined an appointment with his previous GP, stating he would rather discuss with another GP. The plan was to follow-up with another GP. The following day, in a telephone consultation, Billy again reported pain. He denied taking any drugs other than cannabis. He was started on Duloxetine.

4.81. On 1st March Billy attended colorectal clinic regarding the reversal of his colostomy. He also attended clinic on 12th March. On 7th April Billy attended a urology follow-up appointment. On 27th April he attended anaesthetic pre-assessment clinic with the view to proceed with the surgery for reversal of colostomy. On 13th May the last GP contact with Billy occurred for medication review. He reported feeling well, living in his one-bed flat. He reported that his mental health was variable but he denied using alcohol or other drugs. He wanted to continue with mirtazapine and stop duloxetine.

4.82. At the learning event a strong sense emerged of GPs feeling that there was a lack of urgency from other services and limited options in terms of onward referral. In respect of people with dual diagnosis, a view was expressed that an existing protocol between mental health and substance misuse providers works well with people diagnosed with bi-polar or schizophrenia,

but less well with individuals with complex personality disorders. For GPs, especially those working in areas of deprivation, a sense was conveyed that they are left holding the risk in a context where the impact on mental health of physical ill-health, addiction, trauma and poverty is given insufficient priority, and rehabilitation using psychological methods undervalued. For some the learning event was the first occasion in which it seemed that services did actually care.

4.83. Another core component of the evidence-base is "think family." Billy's sisters expressed disappointment that services did not contact any member of the family until the day that he died. In the chronologies there are two references to "thinking family." An Approved Mental Health Professional contacted Billy's mother to establish that she was his nearest relative within the meaning of the Mental Health Act 1983/2007. The housing provider IMR reports that staff had continued contact with Billy's mother. The substance misuse service's IMR explicitly addresses "think family " by questioning whether a key worker could not have asked questions about his support network – important individuals in his life who could offer emotional and practical support, such as accompanying him to his appointments to help with mobility issues. This is a further example of the importance of concerned curiosity. **Commentary:** although living at a considerable distance, there was a missed opportunity to contact family members both to give them an opportunity to share their knowledge of Billy and also to explore what support they might be able to provide. This might be a result of a misunderstanding of the meaning of a right to private and family life (Article 8 ECHR) and the law on information-sharing (Data Protection Act 2018).

4.84. At the learning event practitioners and managers did wonder whether concerns about confidentiality created barriers in contacting family members. They also recognised that, as in Billy's case, Mental Health Act assessments require family contact.

Domain Two: Team around the person

4.85. This domain is principally concerned with how services work together to provide wrap-around health, housing and social care. Included within this focus is legal literacy and safeguarding literacy, information-sharing and the use of multi-agency meetings.

4.86. Working together and information-sharing. Throughout the period under review there are examples where information was shared between services to facilitate working together. Billy's GP received discharge summaries and sometimes telephone calls following hospital admissions. District nurses, practice nurses and Billy's GP exchanged information and concerns about risk in order to ensure that Billy received appropriate treatment. The GP commentary on the chronology for January 2019, for example, records that there was good communication between secondary acute care and primary care relating to Billy's non-attendance at outpatient appointments and consequent concerns. This was repeated in May 2019, for example, regarding treatment that Billy had received in hospital for infections, and again in October 2019 when the GP received information from a diabetic nurse who had assessed and treated Billy in hospital.

4.87. In February 2019 housing provider and ASC staff shared information to ensure that Billy's health, social care and accommodation needs were met when he was facing eviction. An ASC duty social worker alerted the district nursing service and requested a home visit to monitor Billy's skin integrity. An ASC duty worker and housing provider staff member conducted a joint

visit to assess and make arrangements for meeting Billy's health and care and support needs, and to ensure that he was receiving welfare benefits.

4.88. In April and May 2019 information was exchanged between substance misuse service staff regarding assessment and prescribing. Subsequently, that chronology records that information about risk and prescribing was shared with hospital clinicians when Billy was admitted and arrangements were discussed to ensure availability of medication when Billy was discharged, especially because his mobility was compromised due to surgery. Nonetheless, the substance misuse service's commentary for November 2019 questions whether there should have been more effective liaison between hospital, housing, substance misuse and pharmacy staff as part of planned hospital discharge around collection/delivery of his medication.

4.89. Into 2020 there are further examples of information-sharing to facilitate working together. In January and again in June and September substance misuse and pharmacy staff exchanged information to ensure that hospital clinicians had correct details about the medication that was being prescribed for Billy. A hospital pharmacy technician informed the substance misuse service provider when Billy was discharged in order to ensure accuracy and continuity of prescribing care. There are further examples throughout the year when information was exchanged between substance misuse staff and hospital clinicians. Once again there are also examples where district nurses shared their concerns with Billy's GP, and where paramedics shared their assessments of Billy's poor physical health, self-neglect and mental capacity.

4.90. From February 2020 onwards there are instances when housing provider staff shared concerns with ASC staff and with Billy's GP. There were occasions when substance misuse service practitioners liaised with housing provider staff and with Billy's GP, which contributed to a risk update regarding his mental health, suicidal ideation and substance misuse. There were occasions when ASC staff spoke with district nurses, for example at the beginning of April when looking for suitable placements. In May the Healthcare Community Trust chronology records the GP speaking with housing provider staff, which resulted in a plan to monitor his suicidal ideation involving regular room checks, and referring Billy to a pain clinic. The Healthcare Community Trust chronology for early June reports that housing provider staff reported to Billy's GP that he had been observed "*giving things to friends*" outside the hostel. They were concerned that he might be dealing his prescription medications. It does not appear that this was reported to the police.

4.91. The Healthcare Community Trust chronology clearly outlines the liaison that occurred when Billy was in hospital in June 2020 between ward staff and liaison psychiatry, which resulted in Billy being detained under the Mental Health Act 1983. This was also documented appropriately in GP records. The Healthcare Community Trust and substance misuse service chronologies record contact being made by hospital clinicians with district nurses and substance misuse services to ensure smooth transition of provision when Billy was discharged.

4.92. In July, after Billy's discharge from hospital, there were discussions between social care and occupational therapy staff, and also with housing provider staff about how to respond to Billy's care and support needs in his accommodation. Liaison between district nurses and Billy's GP continued to focus on diabetic control and wound management. Liaison between secondary acute care staff, primary care and substance misuse services continued when Billy was admitted into hospital in early September and discharged in November. Billy's glycaemic level was variable

and unstable. He had a perianal abscess, and Fournier gangrene to groin and scrotum. He required surgery to remove infected skin. Surgery removed large portions of his buttocks, anus and scrotum. He had a stoma and catheter fitted which he would need long term. Only 50% of an extensive skin graft had taken and he would need to attend for ongoing outpatient appointments. His prosthetic leg no longer fitted and would need replacing in outpatient clinic. Despite expressed concerns that his accommodation was unsuitable as he could not access the bathroom and there was insufficient room for transfers in his wheelchair, he was discharged back to the same hostel. **Commentary:** this reinforces a concern that there were individual liaisons between services, which continued after his discharge, when a sequence of multi-agency meetings would have been advisable to agree and review the outcomes of a coordinated plan to respond to Billy's complex comorbidities. Regular monitoring was struggling to effectively manage his diabetic control and wound care in the context in which he was living, his variable mood and substance use, and engagement with carers. There was no review of his package of care or reassessment of his priority for rehousing. Accessing his medication and enabling Billy to attend outpatient appointments was seen as a health issue. There is little sense from the chronologies of all services pulling together.

4.93. This picture of information-sharing and staff across services contacting each other continued in 2021. For example, Billy's GP spoke with a substance misuse worker. ASC staff spoke with the care provider agency, for example about invoicing for the care package. The agency also passed on information about failed appointments and liaised with a pharmacy. However, the ASC commentary observes that sometimes it appears that there was a lack of effective communication between ASC and the care provider agency who repeatedly raised issues and in the main were left to deal with the situation unsupported. No action was taken by ASC's locality team, for example in June 2021 when the care provider raised concerns about missed appointments with Billy. The ASC commentary observes that there was no allocated worker to be a point of contact for the care agency so concerns were always dealt with by the contact centre or ASC locality duty team.

4.94. Unsurprisingly, how services worked together and shared information was a significant theme at the learning event. Prior to Billy's eviction and placement in a hostel, housing staff felt that they had received limited information from his landlord, including about safeguarding risks. What information they did receive was not apparently shared more widely subsequently. When floating support had been provided prior to Billy's accommodation in a hostel, copies of assessments by other services had not been provided. A view was expressed that communication between hostel and housing staff could have been improved. It has been reported that Billy was often discussed at bi-weekly panel meetings involving housing provider and local authority housing staff. **Commentary:** such panel meetings are useful opportunities to share information and agree plans but, in Billy's case, no collaborative plan to enable him to move on seems to have emerged

4.95. The care agencies commissioned to provide care and support learned more about Billy at the learning event than had been conveyed in the care plan to which staff were working. Often, care provider staff felt that they were not given the full picture about people referred to them. Care provider staff did not feel that they were "*equal partners*." Overall, a sense was conveyed that how commissioners and providers work together could be improved and that services worked in silos rather than to a coordinated plan.

4.96. Multi-agency (risk management) meetings. A core component of the evidence-base is a recommendation that practitioners and services should come together in case conferences, panels or multi-agency meetings to share information and assessments, and to agree a risk management plan. In particularly complex and challenging cases, the recommendation is that a lead agency and key worker should be agreed with the role and responsibility for coordination the multi-agency effort. Such meetings are one mechanism to overcome concerns about how services work together and share information.

4.97. The GP chronology refers to clinical meeting in January and March 2020 where Billy's situation was discussed. In relation to the latter meeting, the GP commentary observes that not much was documented, making it hard to know how much detail was discussed. This theme is picked up again under the heading of recording below. The GP chronology also references a discussion in a network clinical meeting in November 2020, after Billy's discharge from a long hospital stay but again with little documented detail. Further clinical network discussions occurred in December after Billy had been discharged from a further short hospital admission, and in January 2021. The Healthcare Community Trust chronology also refers to a virtual ward multidisciplinary meeting in January 2021. There is reference to a virtual hub ward round on 4th February and again in the same chronology on 4th March. The GP chronology reports that Billy was discharged then from the virtual ward round. **Commentary:** not all the services involved with meeting Billy's complex and interacting needs were present in these meetings. No clear plan emerges from the chronologies and the rationale for discharge is not given.

4.98. Throughout the period under review not a single multi-agency (risk management) meeting was held. Nor, as the ASC commentary on its chronology observes, was any referral made to the self-neglect and hoarding panel. Such a meeting and/or referral would have been appropriate, for example, in February and March 2020 when Billy had been resident in a housing provider hostel for one year and when staff there were expressing repeated concerns that the accommodation was unsuitable in terms of his physical health and disabilities, and mental wellbeing. In late April a referral would have been appropriate, as the ASC commentary observes, when there were clear indications that Billy was at risk, self-neglecting and selling his medication for money or other drugs, in addition to suicidal thoughts and several falls in his room.

4.99. What this meant was that, despite information-sharing and some coordination in order to meet his complex needs arising from illness, disability and substance misuse, services essentially worked in silos. There was no coordinated plan to provide wrap-around health care, accommodation and social care.

4.100. Unsurprisingly, the use of multi-agency risk management meetings was a significant theme at the learning event, observing that they are crucial to pulling everyone together and identifying a key worker to coordinate how services are responding. It was noted that the operation of the self-neglect and hoarding panel had been revised but psychological services were lacking in this area of work. In addition, there was a reflection that the panel could be more widely publicised. High intensity user meetings had also been adopted and were inclusive of different services and evolving.

4.101. Those attending the learning event on behalf of the different agencies and services that had been involved with Billy recognised that anyone could have convened a multi-agency risk management meeting. However, not everyone felt confident, some services were providing

training to build confidence, and other agencies/services felt that they would need more support if they were to be confident in convening such meetings, having historically not done so. Whilst some optimism was expressed that services are now working in a more multi-disciplinary and multi-agency way, greater ownership of the approach was still needed, with commitment to attend meetings. In a context of stretched resources, attending meetings could be time-consuming and Billy was by no means unique when looking across service workloads. "*In my experience, it is challenging to get all agencies involved to attend the MARM meeting and the importance this meeting has in regard to ensuring the needs of the person are being met and everyone is aware of the risks and a plan in put in place to reduce and review them.*" A question was also asked as to whether multi-agency risk management meetings could be independently chaired, for example to ensure that the agenda is not biased towards the service that has convened the meeting, and to achieve greater consistency and structure. It was observed that this was the model used for child protection case conferences.

4.102. Reference was also made to creative solutions panels, adopted by some partnerships in the south west and elsewhere, providing an escalation route to senior managers when multi-agency risk management meetings and other panels have been unable to mitigate significant risks. A small pilot is apparently underway. It also emerged that "*a creative solutions panel [is available] for people with substance misuse issues open to the treatment system. It is a panel which sits once a fortnight and key workers can present their case, and senior managers then discuss options with the worker. This has been in place since 2016*." This prompted the following reflection: "*I also think it's a multi-agency joint approach for significant complex individuals that is missing. A lot of the complex cases that come to creative solutions for substance misuse once a new complex plan is in place, the clients start engaging and working towards, so only a small minority would need to go any higher panel when multi agency approaches would be needed and to minimise the risks to one agency*." **Commentary:** this highlights the importance again of information-sharing, this time about available procedures and services. This panel was not used in Billy's case. A whole system conversation about the types of multi-agency meetings and panels that would offer useful pathways for practitioners and operational managers would appear to be a useful way forward.

4.103. In line with making safeguarding personal, the learning event also raised the importance of encouraging services to involve the person in multi-agency meetings and, where they were unable to participate, to seek to involve advocates and/or family members, to ensure that their voice is heard.

4.104. Safeguarding literacy. There are three criteria to be met for any referral of an adult safeguarding concern[32], namely that a person has care and support needs, is experiencing or at risk of abuse or neglect (including self-neglect) and, as a result of their care and support needs, is unable to protect themselves from that abuse/neglect. The aforementioned statutory guidance adds a further criterion in relation to self-neglect only, namely that whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.

[32] Section 42(1) Care Act 2014.

4.105. An adult safeguarding referral was raised on 15th March 2020 by the housing provider in respect of Billy's self-neglect; however, this was screened by the ASC safeguarding triage team and passed over to the ASC Locality Team with no further action under safeguarding. The outcome was that this referral was placed on the waiting list with a team manager to determine priority. On the 23rd of March 2020 the ambulance service raised a second safeguarding concern relating to self-neglect and his accommodation not meeting Billy's needs. This was also not followed up by the ASC safeguarding team but was passed to the ASC Locality Team to manage. The ASC commentary on these adult safeguarding referrals concludes that there was no evidence of a risk assessment and that Billy's situation should have been referred to the self-neglect and hoarding panel at the very least. **Commentary:** both adult safeguarding referrals were appropriate and the criteria in section 42(1) were clearly met. Billy was not safeguarded.

4.106. Of concern throughout the period under review is that, despite the clear evidence of self-neglect, no other adult safeguarding concerns were referred to the local authority until 7th July 2021 when the agency providing Billy's package of care and ambulance service both highlighted their concerns. Section 1.9 above records the conclusions of the adult safeguarding enquiry that followed. **Commentary:** both care provider agencies might well have referred adult safeguarding concerns when Billy was declining care and support in a context of self-neglect.

4.107. There were, therefore, missed opportunities to refer adult safeguarding concerns both when Billy was in hospital and when he was known to be selling his medication and/or refusing treatment and care and support. In October 2020 the Healthcare Community Trust chronology and commentary refers to discrepancies in information exchange when Billy was in hospital about unspecified safeguarding issues and that there were no active safeguarding concerns. The housing provider chronology records a telephone call from ASC to the effect that a safeguarding review was being prepared. The ASC chronology for the same time refers to a planned review but it is unclear whether this was specifically in relation to safeguarding or more generally in relation to his care package. The GP commentary on the chronology recognises that the GP practice had not identified Billy as a safeguarding risk. Similarly, the commentary on substance misuse provider engagement observes that "*self-neglect was evident throughout, however [there were] no further communications/onward referrals to either the Local Authority safeguarding team or Healthcare Community Trust Safeguarding team for advice and guidance*."

4.108. At the learning event missed opportunities to refer and to respond to adult safeguarding concerns were recognised. Questions were asked about when self-neglect should be referred to the self-neglect and hoarding panel, and when as an adult safeguarding concern, or when a multi-agency risk management meeting should be convened. **Commentary:** this suggests that staff in all agencies might be unclear about the interface between the different pathways. Anyone can refer into the self-neglect and hoarding panel.

4.109. <u>Legal literacy</u>. On 2nd April 2020 ASC were informed that a letter had been written by Housing to inform Billy that, as he was not homeless or being threatened with homelessness, he was not considered to be a priority. He was apparently placed on bronze banding, later revised to silver. The view might have also been that, since his physical health was being managed, Billy was not vulnerable. At the same time and regularly thereafter hostel housing provider staff continued to express their concerns that hostel accommodation was inappropriate for meeting his needs and that he was at high risk.

4.110. Even if one accepts for the moment that his health needs were being managed, and acknowledges the shortage of social housing, it is clear from the combined chronology that staff found it increasingly difficult to manage and meet his physical and mental health needs. It is equally clear that the GP and others flagged up the risks to his physical health and mental wellbeing. **Commentary:** people will find it more difficult to recover from mental health or substance misuse problems, and to manage physical disabilities and ill-health without secure housing.

4.111. Billy was a disabled person but there is no sense of reasonable adjustments having been made in line with the requirements of the Equality Act 2010. A key question is whether Billy had a priority need. Throughout the period being reviewed, the judgement of housing staff appears to have been that he was not. The Housing Act 1996 and subsequent case law have established that a person would be in priority need if vulnerable as a result of mental illness, learning disability or physical disability. Billy would be vulnerable if less able to fend for himself than an ordinary person so that injury or detriment would result when a less vulnerable individual would be able to cope without harmful effects[33].

4.112. Since the relevant amendments made by the Homelessness Reduction Act 2017 came into force, any applicant who is threatened with homelessness (and Billy would have been homeless but for the provision of hostel accommodation) and eligible for assistance will be owed some duty regardless of priority need. Their case must be assessed, and the authority must seek to agree a personalised housing plan (section 198A). The authority is required to take reasonable steps to help the applicant secure accommodation (section 189B). No clear plan for enabling Billy to move on from hostel accommodation is evident. Responsibility once again seems to have been left with the housing provider to explore alternative options.

4.113. The ASC chronology does not evidence that section 23 Care Act 2014 and the statutory guidance on the relationship between accommodation and care and support was considered when Billy's care and support needs were assessed. Nor is it clear whether, when Billy declined a care and support assessment (section 9), the provisions of section 11 were considered. Equally, it is unclear whether anyone in ASC considered whether to waive the charges being levied for his package of care, since charging for home care is a power rather than a duty.

4.114. The ASC commentary also observes that guardianship (section 7 Mental Health Act 1983) could have been considered, for example when consideration was being given to detaining Billy under section 2 of that Act and subsequently when that section was discharged. That commentary also observes that advocacy could have been considered, as provided for in the Care Act 2014 as well as in mental capacity and mental health legislation. **Commentary:** at the learning event, questions were asked about whether different options available in law were considered.

4.115. <u>Recording</u>. Critical observations are made about recording standards in several of the commentaries that have accompanied individual service chronologies. The commentary on substance misuse service provision is critical of the standard of recording of risk assessments and of not checking with other services for the accuracy or triangulation of risk assessment information. It suggests that information in the risk action plan could have been clearer, for

[33] Hotak v Southwark LBC [2015] UKSC 30

example about what attention was being given to Billy's mental health. On one visit to Billy's flat in late May2021 there is no reference to his home environment.

4.116. The GP commentary also offers some critical observations, for example about recording of discussions with Billy regarding his mental health, the risks associated with opiate use and what was planned by way of response. When Billy reported to his GP that he had lost his medication, it is unclear whether this story was believed or whether there were concerns that this was fabricated to get more. On occasions not much was documented regarding discussions with Billy, making it hard to know how much detail was discussed regarding self-neglect, mental health and risks associated with poor diabetic control.

4.117. The ASC commentary focuses on use of records and observes that "*there was evidence of a lack of communication between ASC professionals and recording systems were not always checked when decisions were made not to follow up on concerns*." It recommends that "*All ASC staff to be reminded of the need to gather all available information from other sources, such as family members and other professionals involved in the individual's life when undertaking an assessment of need and to check all local IT recording systems when decision making.*"

4.118. The ambulance service commentary reports that paramedics have no access to the mental health digital system, RiO. They might have access to the NHS Spine and Summary Care Record if the crew has a smart card and their role-based access controls are set up correctly.
Commentary: all staff in partner agencies need access to available information, especially in emergency situations, if they are to have the opportunity to formulate the best assessments and responses possible.

Domain Three: Organisational support

4.119. Policies and procedures. There was at the time no written guidance available with regards to how the ASC Locality Team were prioritising the allocation of work. Therefore, decisions were not recorded and have not been available as evidence to show the rationale. As the ASC commentary observes, this exposes the department to challenge. **Commentary:** one standard within administrative law, drawn on in judicial reviews and in scrutiny by the Local Government and Social Care Ombudsman, is that reasons for decisions should be recorded. At the learning event some uncertainty emerged regarding whether procedures were available and/or up-to-date.

4.120. There is little reference to supervision and management oversight in the chronologies. On 31st March 2020 the ASC chronology records a discussion between a social worker and practice manager that resulted in an occupational therapy assessment being deferred until required to contribute to his re-housing. If there was any escalation of concerns to senior managers, this has not been recorded in any of the chronologies. One care provider agency, in its reflections on learning, has highlighted the importance of management oversight of clients at risk of self-neglect to ensure that adult safeguarding measures are put in place. The housing provider in its reflections on learning has also emphasised that concerns could have been escalated to senior managers when other agencies were slow to respond.

4.121. At the learning event, quality supervision was acknowledged as having been missing in Billy's case, although there were examples elsewhere of good reflective and supportive supervision,

and its importance restated. BCP SAB is undertaking some work on safeguarding supervision. As highlighted at the learning event, practitioners' and managers' lived experience of work can leave them feeling tired, stressed and overwhelmed. Supervision and line management support are therefore crucial if standards of work are to be maintained.

4.122. Workloads and resources. There were waiting lists for occupational therapy and care and support assessments when Billy was referred to ASC in February/March 2020. There were delays in responding to Billy's wheelchair requirements as a result of a large backlog, and some difficulty in finding a care provider agency to meet Billy's assessed care and support needs in April 2020. There are also references in the ASC chronology around December 2020 to a backlog of cases awaiting review and the ASC commentary records concern that Billy's case was given insufficient priority between then and March 2021, with the result that housing provider and care agency staff were left holding the risk. The ASC commentary is firmly of the view that Billy should have been identified as a priority by management for a review of the whole situation.

4.123. There are references to a lack of available psychiatric beds when Billy was sectioned under the Mental Health Act 1983. The absence of a moving-on plan for Billy once he was accommodated in the housing provider hostel might also be reflective of a lack of social housing and other options. The contribution from substance misuse services highlights the high workloads being carried, which increased further during the pandemic, and which exceeded recommended levels in the Dame Carol Black review[34].

4.124. Unsurprisingly, workloads and resources were a prominent theme at the learning event. One strand of concern focused on the allocation of resources. Criticism was expressed that resources had been targeted towards older people and away from younger patients with multiple health care challenges. Concerns were expressed regarding gaps in mental health services, for example to support people with complex trauma or long-term conditions. *"There also needs to be a focus on mental health services for children/young adults. There is so little available. Often by the time we try to intervene it is already too late and the damage from the early trauma is already set in. It then becomes very difficult to get patients like Billy to engage as an adult."* Commissioners struggled to find providers for what were termed "*exceptional cases*." Again, "*no ongoing mental health support was offered*."

4.125. A second strand of concern was that it remained challenging for staff to keep cases open in the face of someone's apparent reluctance to engage. Practitioners and managers recognised the pressures placed on staff to reduce waiting times and to increase workloads, which led to challenges in keeping cases open where more time to build relationships of trust was necessary. *"There is currently encouragement to not keep cases long-term due to unmanageable waiting lists/waiting times. Turnover is expected rather than long term work encouraged." "Yet relationship building is deemed crucial but no one is given the time to do it!"* Candid views were expressed that ASC is "*under-resourced, under-funded and over-used*", with a consequent need to "*navigate with what we have to make the most positive impact on the people we are working with*." One response has been the development of the strengths-based conversation approach. Also observed were positive relationships between local authority and health service commissioners. However, further thought needed to be given to the management of waiting lists and how allocation balances complexity of need and risk against the volume of work carried

[34] Black, C. (2021) *Review of Drugs, Part 2, Prevention, Treatment and Recovery*. London: The Stationery Office.

by staff. Views were also expressed that there should be further whole system conversations, involving all partner agencies, about how to manage risks and demands against available resources.

4.126. Expressions of concerns about resources did not just focus on ASC. Across services there was recognition of the importance of relationship-based, person-centred practice, which required time. However, *"these practices are extremely important to consider, and I will certainly make more effort to do them. But they are also extremely time consuming. We, sadly, have multiple patients like Billy. Until funding starts following people like Billy it is practically hard to manage things according to 'best practice' even if we would like to."* Again, *"I see that its 'easier' to close the referral when people don't engage, so you can move on to the next case (as there are waiting list pressures); that's the reality at the front door [and we] need a strategy we all adhere to. [Billy's case} was closed despite the care agency requesting reviews and multi-disciplinary team discussions."* Again, *"this is particularly difficult within an integrated teams where the health or social care side want to keep a case open, but the other closes (e.g. within a CMHT). One side is left without the others' involvement despite being set up as an MDT."*

4.127. Shortage of resource was also felt to impact on providers of care and support. Thus, "*care providers are only commissioned to do short calls with individuals which makes it very difficult in these cases to be able to spend time with them to get them to engage fully."* Questions were asked about whether commissioners record when care provider agencies raise such concerns and how they respond. A sense was conveyed that providers had expressed such concerns in Billy's case but had not received a response.

4.128. Suggestions for service development were also offered at the learning event. Thus, "*I believe that with complex cases like Billy who do not easily engage there needs to be a long-term social worker / team to get to know the person - to find out what makes them tick - to find out what obstacles they need to overcome. They would then be able to coordinate health needs, services and other involved parties. There can be a diffusion of responsibility when so many people are involved. This however is time consuming but I think less expensive in the long run - often our work is too focused and short-term - going from one social work team to another, for example hospital, to locality, to mental health."* Again, *"we probably need some guidance for practitioners on working with complex individuals as these seem to be increasing in all services and everyone is scrambling around trying to meet their needs."*

4.129. Policies and procedures are crucial underpinnings for professional practice since they provide a framework to support best practice. Several management reports reflect learning about the importance of raising awareness and ensuring implementation of available policies and procedures. Thus, one care provider has reminded staff of its protocol on non-response to ensure that adult safeguarding concerns are referred. It has reminded staff of the policy and procedures relating to access to people's homes. ASC has observed shortcomings in the use of the policy on failure to gain entry. Use of the guidance on multi-agency risk management meetings was also highlighted, for example in reflective management reports from the housing provider and primary care.

4.130. ASC's reflections on learning highlight that there was no written guidance about how work was to be prioritised, for example by ASC locality teams. It observes that this resulted in there being no record of decisions. Guidance is now available.

4.131. Covid-19 pandemic. It is important to note that during the period between February 2020 and Billy's death in July 2021 there was a worldwide pandemic sweeping through the country. This led to several periods of lockdown measures having been implemented by the Government of varying degrees. This resulted in BCP Council introducing restrictions to how services were delivered over this period. Staff in ASC were advised to work from home and face to face visits were very limited. This inevitably impacted on the level of support and interventions by ASC for Billy. However, the local authority did not formally ease their statutory duties as permitted by the Coronavirus Act 2020. Other providers, for example substance misuse services and social housing organisations, also altered their patterns of work and/or believed that there had been an impact on multi-agency working. For some staff, for example in primary care, face to face work continued albeit with enhanced precautions. It has been suggested that, across services, practitioners and managers are "*still reeling from the pandemic*" in terms of volume and complexity of the work.

4.132. The pandemic had also impacted on the introduction of, and training for a dual diagnosis policy. What was also recognised at the learning event was the impact of the pandemic, and especially of the lockdowns on people's social isolation and mental wellbeing. For people experiencing poverty and ill-health, such as Billy, the impact was believed to have been significant and questions were asked about whether technology could have been used more effectively as a safeguarding intervention.

Section 5: Concluding Discussion and Recommendations

5.1. Single agency management reports submitted for this SAR contain reflections on learning from how services worked with Billy and with each other. Police have highlighted the need for a wider discussion about the circumstances under which police officers will undertake welfare checks when requested by other agencies. This links with debates nationally about Right Care, Right Person. Concern about the impact of the introduction of Right Care, Right Person by the police was also expressed at the learning event. **Recommendation One:** BCP SAB should consider how it can raise awareness across the multi-agency partnership regarding when police services have a statutory mandate to undertake welfare checks and to assist other practitioners to complete their statutory mental health and safeguarding duties.

5.2. The GP submission contains several important commitments to build on learning from how healthcare providers worked with Billy and together. Firstly, Billy had not been identified as a safeguarding risk and, therefore, concerns were not referred. Secondly, "*as Billy had significant health conditions, sometimes these appeared to take priority so he was managed very well clinically with antibiotics etc., but the underlying concerns in relation to his mental health and self-neglect were sometimes lost in this process. It is clear they were a major factor in his deterioration, and had they been identified and acted on earlier he could have had some more support prior to his health deteriorating*." **Commentary:** this is a reflection about the risks of diagnostic overshadowing. The substance misuse analysis of learning also highlights that focus was given in that service to his prescribing needs rather than to his wider health and care needs.

5.3. Thirdly, GPs experienced difficulties in bringing the whole health, housing and social care system together, although there were occasions when multi-disciplinary meetings were held. The reflective contributions from substance misuse services and the Healthcare Community Trust also highlight that working together occurred in response to specific events and did not adopt a proactive multi-agency approach to meeting Billy's needs and mitigating risks. The housing provider has also identified the use of multi-agency meetings as an area for improvement. Fourthly, when Billy did engage, longer appointments might have been helpful to address the needs and risks with which he was presenting, and to review his mental capacity, including executive functioning. Finally, review of working with Billy has highlighted the importance of GPs seeking advice from safeguarding specialists in the ICB and local authority when they are feeling hopeless, helpless and/or "stuck" when trying to prevent escalation of needs and risks. The same point is made by the Healthcare Community Trust, reminding staff to seek advice from safeguarding specialists. **Recommendation Two:** BCP SAB should consider how it could support primary care clinicians and the ICB to establish and maintain systems that enable recognition of adults at risk and a safeguarding response to self-neglect. **Recommendation Three:** BCP SAB should consider how to further embed in practice the use of multi-agency risk management meetings, now that guidance has been revised and reissued. **Recommendation Four:** BCP SAB should consider whether further work is necessary with all partners to raise awareness of diagnostic overshadowing[35].

5.4. The GP commentary and the contributions from substance misuse commissioners and providers, and from the Healthcare Community Trust acknowledge the need to improve recording of

[35] Attributing presentation to a psychiatric problem when symptoms suggest comorbidity, resulting in shortcomings in holistic assessment of needs.

assessments, discussion of treatment options and decision-making, of adherence to policies and procedures, of significant events such as admission under the Mental Health Act 1983, and of responses to missed appointments. The management report regarding substance misuse services reflects that there was no apparent consideration of Billy's executive functioning, nor of convening a multi-agency risk management meeting. The latter concern has already been captured in recommendation three. The Healthcare Community Trust has observed that, whilst there is evidence of some completed mental capacity assessments, there were occasions when assessments should have considered Billy's decision-making when there was evidence of self-neglect. The housing provider has reported that staff are "*unable to assess capacity*." Mental capacity assessments should, where possible, be undertaken by staff who know the person best, accompanied where appropriate by other practitioners with knowledge and skills relevant to the decision that is the focus of the assessment. **Recommendation Five:** BCP SAB should consider whether and how it would be appropriate to seek assurance about recording standards of assessments, risk and decision-making. **Recommendation Six:** BCP SAB should consider how it can support staff to ensure that executive functioning is considered in mental capacity assessments.

5.5. The substance misuse commentary on learning observes the absence from recorded notes of recognition of self-neglect and of Billy's voice and involvement in decision-making. Recording standards have been covered in recommendation five but concerns about recognition of self-neglect connects with observations at the learning event and in chronologies about the omission of referring Billy to the self-neglect and hoarding panel. ASC in its submission to the review recommends further work to promote referrals to the self-neglect and hoarding panel. **Recommendation Seven:** BCP SAB should consider how to promote referrals to the self-neglect and hoarding panel. **Recommendation Eight:** BCP SAB should consider whether to commission a multi-agency audit of case files for assurance that making safeguarding personal is embedded in practice. This could usefully include a focus on advocacy provision to ensure that people are enabled to contribute to assessments and decision-making.

5.6. Highlighted above is the recognition that Billy was not identified as a safeguarding risk, which explains why he was not referred under the provisions of section 42(1) Care Act 2014. The substance misuse commentary also observes the absence of safeguarding referrals from that service. The ASC submission also criticises decision-making when adult safeguarding concerns were referred to the local authority. **Recommendation Nine:** BCP SAB should consider whether to seek assurance about decision-making and the management of risk when adult safeguarding concerns are referred to the local authority.

5.7. The substance misuse reflective analysis highlights two points of learning for commissioners. One refers to the lack of psychosocial support that was offered to Billy. The housing provider has also expressed concern about the absence of mental health outreach support for Billy. The other observes that reliance was placed on providers to meet quality standards rather than using audits to monitor whether providers were compliant with expectations of service provision. This resonates with a theme in the learning event about gaps in provision. **Recommendation Ten:** BCP SAB should consider whether to convene a summit of commissioners and providers to review procedures for monitoring standards and to appraise where there are gaps in service provision that integrated commissioning might seek to remedy.

5.8. Returning to the key lines of enquiry for this SAR, the following conclusions appear justified.

5.8.1. What planning and transition work took place with Billy to support him when he moved? There was no move-on plan when Billy was first admitted to the hostel. Housing provider staff took on the responsibility for finding Billy more appropriate accommodation and ensured that he was supported until the new care provider agency service could commence.

5.8.2. Given Billy had been previously detained under section 2 of the Mental Health Act 1983, what actions were taken following this to support him to move back home and live safely? Given Billy's complex history of risk and knowledge that stress triggers suicidal ideation, what safeguards were put in place to support him at this time? Billy was offered mental health support but declined and there was insufficient curiosity/exploration of his reasoning. Assertive outreach did not seem to have been considered.

5.8.3. Learning for all agencies around assessing risk and the use of multi-agency risk management procedures, specifically to examine practice in terms of risk assessment and the escalation of high risk cases. The agencies involved have voiced criticisms of risk assessments, have acknowledged that concerns were not escalated, and have recognised that further work is required to embed the use of multi-agency meetings in practice.

5.8.4. Examining whether, given the concerns which professionals had about Billy's lack of engagement, a formal mental capacity act assessment was undertaken and if so what was the outcome and how did professionals follow up on this? Was executive capacity considered? Was Billy able to weigh up and consider the risks of his decision-making around medication and poor engagement with professionals? Practice regarding mental capacity assessments was variable, as earlier sections of this review have identified. The ASC management report concludes that there were grounds for questioning Billy's capacity and that enlisting the support of mental capacity advocates does not appear to have been considered. Paramedic recording of some mental capacity assessments was clear.

5.8.5. Analysis of self-neglect and actions to support minimising risk where Billy was considered to have capacity. Several management reports and contributors at the learning event acknowledged that referrals should have been sent to the self-neglect and hoarding panel. This is one example of where available procedures were not accessed. As the ASC management report concludes, and as earlier sections of this review have emphasised, focused concerned curiosity conversations were necessary with Billy to appreciate how he viewed his situation and why he made the decisions that he took. He gave some glimpses into his experience, for example when he declined hospital admission, seeing treatment as futile because of the state of his veins. Concerned curiosity would have enabled practitioners to have been clearer on what the risks and issues were.

5.8.6. To consider the impact of Covid-19. Were agencies delivering physical contact? If not how was contact with Billy maintained and risks understood/managed? As highlighted in earlier sections of this review, the pandemic resulted in significant changes to working practices for some agencies, contact with Billy having become virtual. However, Billy did have in-person contact with some staff. What has less apparent has been the social and emotional impact of the pandemic on Billy.

5.8.7. Examine whether any safeguarding concerns had been referred and if so what was the response and what actions were taken following receipt of those concerns? Several agencies in their reflective submissions for this review have suggested that there should have been more referrals of adult safeguarding concerns for self-neglect and that training has been, or would be provided to raise staff awareness. The ambulance service has also observed that the paramedic service does not routinely receive feedback on adult safeguarding referrals or the outcomes of multi-agency meetings.

5.8.8. Analysis of communication between agencies. Analysis of social work and health practitioner involvement and management. ASC's reflective submission for the review concludes that there was a lack of communication between staff within the department. Across the agencies involved, although there were examples of liaison and communication, as this review has reported in earlier sections, the overall conclusion was that services tended to work in silos and that information-sharing and communication should be strengthened. When Billy was discharged from hospital is one instance where how agencies work together could have been strengthened to coordinate plans to meet his health, housing and social care needs and to attempt to mitigate risks.

5.9. There have been some service improvements since Billy died. Within substance misuse services several improvements have been introduced. Mental health support workers have been appointed for people experiencing or likely to experience homelessness. Counsellors have been recruited to support people's substance misuse recovery from complex trauma. A new substance misuse service provider has been commissioned and a social worker is now located within the drug and alcohol service to work with people with multiple complexities and at risk of eviction. Motivational interviewing is now a standard approach in use by all workers within the treatment system. A drug and alcohol housing support team is currently being recruited for individuals who are at risk of eviction or if they have complexities which mean that engagement might be difficult for them. Work is currently underway to raise awareness of the drug and alcohol housing support team to social housing providers and private landlords. The independent reviewer has been told that, in relation to hospital discharge, multi-agency meetings are now taking place involving, for instance, hostel providers. There is a self-neglect and hoarding practitioner drop-in every other month, open to all agencies, at which cases can be discussed.

5.10. In conclusion, it is important to recognise that some staff involved with Billy "*went above and beyond*", supporting him practically and emotionally with activities of daily living. Contributors at the learning event stressed that many staff members are "*wanting to do their best, research options available and then go back and try again*." However, the good practice that did happen took place more in isolation than as part of a multi-agency plan.

5.11. Nonetheless, shortcomings, and the reasons why they occurred, have been identified by this review. Billy's relatives continue to grieve for him and have found the circumstances leading up to his death distressing. It is to be hoped that this review, and the commitment of the services involved to improve practice and the management of practice will provide Billy's family with some reassurance and closure. **Recommendation Eleven:** BCP SAB should consider holding a learning event after one year to evaluate what progress has been made in implementing the recommendations made by this review. Billy's relatives could be invited to participate in order to hear what changes in practice and the management of practice have occurred.

5.12. The recommendations have been addressed to the Bournemouth, Poole and Christchurch Safeguarding Adults Board in the expectation that all partners will engage in the development of an action plan, with clearly allocated roles and responsibilities, and a timetable for expected implementation and review. Essentially, the recommendations aim to facilitate practice and service development, not just in relation to self-neglect but adult safeguarding more widely.

Recommendation One: BCP SAB should consider how it can raise awareness across the multi-agency partnership regarding when police services have a statutory mandate to undertake welfare checks and to assist other practitioners to complete their statutory mental health and safeguarding duties.

Recommendation Two: BCP SAB should consider how it could support primary care clinicians and the ICB to establish and maintain systems that enable recognition of adults at risk and a safeguarding response to self-neglect.

Recommendation Three: BCP SAB should consider how to further embed in practice the use of multi-agency risk management meetings.

Recommendation Four: BCP SAB should consider whether further work is necessary with all partners to raise awareness of diagnostic overshadowing.

Recommendation Five: BCP SAB should consider whether and how it would be appropriate to seek assurance about recording standards of assessments, risk and decision-making.

Recommendation Six: BCP SAB should consider how it can support staff to ensure that executive functioning is considered in mental capacity assessments.

Recommendation Seven: BCP SAB should consider how to promote referrals to the self-neglect and hoarding panel.

Recommendation Eight: BCP SAB should consider whether to commission a multi-agency audit of case files for assurance that making safeguarding personal is embedded in practice. This could usefully include a focus on advocacy provision to ensure that people are enabled to contribute to assessments and decision-making.

Recommendation Nine: BCP SAB should consider whether to seek assurance about decision-making and the management of risk when adult safeguarding concerns are referred to the local authority.

Recommendation Ten: BCP SAB should consider whether to convene a summit of commissioners and providers to review procedures for monitoring standards and to appraise where there are gaps in service provision that integrated commissioning might seek to remedy.

Recommendation Eleven: BCP SAB should consider holding a learning event after one year to evaluate what progress has been made in implementing the recommendations made by this review. Billy's relatives could be invited to participate in order to hear what changes in practice and the management of practice have occurred.

Last Words

Billy's sisters have wanted to emphasise that we should remember not just the challenges that Billy faced in his life but also his qualities as a son, brother, uncle, cousin and nephew. I have had the privilege of seeing photographs of Billy with his family. I have also been able to read screenshots of text messages, cards and letters. Billy's sisters have emphasised to me the love and affection that Billy showed towards his family, and the family towards him. I have seen first-hand evidence

of that and hope that, in responding to the findings and recommendations of this review, we will also remember the quality of those relationships.