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**Safeguarding Adult Review – Elaine**

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1. **Introduction**

Elaine[[1]](#footnote-1) was an 80 year old white British woman who died in 2021. On 6 July 2021, neighbours became concerned about the lack of noise coming from Elaine’s flat over the previous week and called the Police. She was found dead in her home. Elaine had a background history of depression, emotionally unstable personality disorder, excessive alcohol use, self-neglect and non-engagement with professionals.

A Section 44 referral for a safeguarding adult review (SAR) was submitted by North Yorkshire Council Health and Adult Services Directorate as a result of concerns about the lack of a coordinated response, workers’ understanding of working with people at risk of self-neglect and indicators of risk that were not escalated.

The Safeguarding Adults Board (SAB) Learning and Review Group, which makes decisions on proceeding to a SAR, agreed that the case highlighted a number of areas of potential learning, and decided that a SAR should be undertaken. This SAR considers a period from July 2020 until Elaine’s death in July 2021.

1. **Purpose of the Safeguarding Adults Review**

The purpose of SARs is to gain, as far as is possible, a common understanding of the circumstances surrounding the death of an individual and to identify if partner agencies, individually and collectively, could have worked more effectively. The purpose of a SAR is not to re-investigate or to apportion blame, undertake human resources duties or establish how someone died. Its purpose is:

* To establish whether there are lessons to be learned from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults.
* To review the effectiveness of procedures both multi-agency and those of individual agencies.
* To inform and improve local inter-agency practice.
* To improve practice by acting on learning.
* To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

There is a strong focus on understanding issues that informed agency/professionals’ actions and what, if anything, prevented them from being able to properly help and protect Elaine from harm.

1. **Independent Review**

Mike Ward was commissioned to write the overview report. He has been the author of fifteen SARs as well as drug and alcohol death reviews and a member of a mental health homicide inquiry team. He worked in Adult Social Care for many years but in the last decade has worked mainly on developing responses to change resistant dependent drinkers.

1. **Methodology**

A multi-agency panel of the North Yorkshire Safeguarding Adult Board was set up to oversee the SAR and commissioned the author to complete the review. Initial information was sought from agencies involved with Elaine by requesting chronologies.

It is important to note that North Yorkshire SAB wanted a swift process and, therefore, it was agreed to develop the final report using the information and chronologies supplied, rather than seeking more detailed Individual Management Reports. This also reduced the work impact on the agencies involved. More detailed information was sought from the involved agencies via a Practitioners’ workshop in July 2023.

The following agencies were involved in the process:

* Humankind North Yorkshire Horizons (Alcohol and Drug Service)
* Tees, Esk and Wear Valleys NHS Foundation Trust (Mental Health Trust)
* Primary Care
* Yorkshire Ambulance Service
* North Yorkshire Police
* Harrogate and District Foundation Trust
* North Yorkshire Council (Prior to April 2023 - North Yorkshire County Council)

Some of the information provided included information from outside the review’s time period enabling a fuller picture of Elaine to be developed. All of the material was analysed by the author and an initial draft of this report went to the Review Panel in August 2023. Further changes were made over the next two months, and a final draft was completed in February 2024.

1. **Family contact**

An important element of any SAR process is contact with family. Elaine had a younger sister living in the Yorkshire region. She was contacted in order to engage her in the process and both a representative of the SAB and the SAR author had conversations with her. Her comments and perceptions have been hugely helpful in developing this report. The author is very grateful for her input.

1. **Parallel processes**

There were no parallel processes such as Police or Coronial inquiries that coincided with the review.

1. **Background and personal Information**

In July 2021, neighbours became concerned about the lack of noise coming from Elaine’s flat and called the Police. She was found on the bedroom floor deceased, and it appeared that she had been there some time. She was last seen 10 days previously by a man who did food shopping for her. There were no signs of forced entry, and there were several empty bottles of alcohol around the flat. The post mortem reported the cause of death as “unascertained” and the Coroner deemed it to be “natural causes”.

Elaine lived alone in a second floor privately rented flat where she had lived for over 20 years. In 2018 she was talking about the need to apply for re-housing to a ground floor flat; this never occurred. However, in the last year of her life, she was under threat of eviction from her landlord due to concerns about emergency services breaking into the property.

It is easy to simply visualise Elaine as an isolated older woman tragically dying alone in her flat. However, if we look beyond that we see someone who lived a very varied, interesting and challenging life. Elaine was a woman with interests such as history and travel. She had a circle of friends (mainly older than her) with whom she spent time. In 2015-2016 she was still actively trying to maintain her social circle and occupations. She used to do voluntary work and made friends working with WRVS. However, the Mental Health Trust felt that this friendship circle began to dwindle after 2018.

At the time of Elaine’s death, a much younger member of her family sent a card to Elaine’s sister saying that: “*I’ve been reflecting a lot on my memories of her and how I only have happy ones and feelings of love towards her.”*

A worker who knew her commented that: “*she was an incredibly independent woman and I think she did recognise that she needed help, but she was also very stubborn … I found her very engaging. Even though she would tell me to go away quite a lot … I enjoyed her company, we did have times where we sat and chatted, and she told me about her life. And life really was a struggle for her… she did fight to try and keep on top of her life.”*

Elaine had an alcohol use disorder and, in the last five or six years of her life, was regularly drinking two bottles of wine per day. A 2016 assessment report indicates that she linked the drinking to “the death of her husband, 20 years previously”. However, it transpires that Elaine was never married. She was in a relationship with a married man who eventually left his wife and lived with Elaine for a couple of years before he passed away. This was much further back than 20 years and was probably as many as 40 years previously. However, it is reported that she had many pictures of him in her flat at the time of her death. Irrespective of the accuracy of the reporting, this would appear to be a significant emotional, and probably traumatic, episode in her life.

Beyond the death of her partner, Elaine identified two other aspects of her life that had caused her emotional pain. In the 2016 assessment, she reported that as a “young girl” she had to give her baby up for adoption and that this had significantly affected her throughout her life. Again, this appears not to be true, but to conceal another trauma. She became pregnant by her married partner but had an abortion. As part of that abortion, and under very controversial circumstances (which will not be discussed here), she also had an enforced sterilisation.[[2]](#footnote-2)

She also talked about a close platonic relationship that she had with a man until 2015. This lasted for twenty years but she reported that he met another woman and decided he wanted “more out of life”. The ending of this relationship appears to have been a significant loss for Elaine.

In the last years of her life Elaine was probably living with significant trauma; she also reported feeling isolated and associated this with her drinking. Nonetheless, she did have a sister and a niece who were involved in her care at points. She also had a female friend and a male neighbour who did some shopping for her.

However, she could also be very difficult with her friends and family. One member of her family described her as sometimes “being foul” to other people. As a result, at one point the relationship between the siblings broke down, with Elaine stating that she did not want any information to be shared with her sister. This was being resolved towards the end of her life.

Reports on Elaine, dating back to 2016, indicate that alcohol use was a problem for her. In a 2016 needs assessment she is noted as saying: *“I have issues with alcohol abuse.”* She goes on to say, in a very clear-sighted manner: *“I have been a heavy drinker. I'm not sure if I could keep myself safe in the flat because if I started drinking again, it would impair my judgement.*” In 2018 Elaine was admitted to hospital with alcohol withdrawal. The pre-discharge report says that *“Excess alcohol intake is an issue, however, Elaine is aware of the risks and chooses to continue drinking to excess.”*

In 2021 it was reported by the Hospital that she was aware she had issues with alcohol. She was calling a taxi daily to buy her alcohol, and that her daily intake was approximately two bottles of wine (12-20 units per day). However, she also generally and repeatedly refused to engage with local Alcohol Services.

As well as her alcohol use, professionals had long-standing concerns relating to her mental health, suicidality, physical health concerns and, in particular, her self-neglect.

She had a longstanding history of recurrent depressive disorder, emotionally unstable personality disorder and had overdosed on several occasions. For example, in 2016 she overdosed on 20 co-codamol tablets. As a result, she was known to the local Community Mental Health Team (CMHT) for the last 10 years of her life. Elaine herself said: “*I have felt very suicidal and made several attempts to end my life. I wish to go to sleep and never wake up.”*

Her ability to care for herself deteriorated over the years from 2016. In a needs assessment of that year, she stated that: “*(I) don't need support with washing and dressing when well. When I was at home drinking and started becoming depressed, I would choose to self-neglect. I'd spend most of the day in bed in nightwear and not be bothered to get washed or dressed.”* She also said that: “*I am able to make meals and get food when well. When drinking, I choose to neglect to eat and will just drink all day. I feel I would need a bit of support … with food shopping initially, but apart from that I can cope as I used to do my own shopping and cooking before.*

In 2018 Elaine was described as having capacity to make all decisions for herself. She could walk without aids and was independent with managing her own personal care and getting her own meals. A North Yorkshire County Council Independence Assessment Report (a Social Care Assessment) described her as *“an independent lady. She does not require support with any care needs and states that she does not want any help at home other than to help with practical tasks - the carpets need cleaning.”* However, it is acknowledged that this situation can change when *“she drinks excess alcohol, then she does not eat properly and she neglects her personal care.”* As a result, her family already felt at that point that she needed to be in a care home.

By 2020, she was using a Zimmer frame and was struggling with the stairs to her flat. A second Independence Assessment Report (from the Council) says that Elaine: “*Neglects to eat and drink sufficient at home to keep well … Is able to wash, dress and undress her own top half when in a seated position. Support is required to manage lower body and back. Neglects her personal hygiene when home alone. Currently needs an escort when going to and from the toilet but this is only until she is safe to walk on her own. She will ring for help when needed.*”

Elaine was open about the fact that she was not looking after herself properly or eating adequately. In July 2020, a safeguarding concern was raised due to conditions at home and her lack of engagement. In August 2020, Elaine was admitted to hospital due to feeling unwell and reporting suicidal thoughts. On discharge, she had a short stay in a Care Home, and then returned home with support. However, her engagement was described as *“intermittent”*. In January and February 2021, there was ongoing evidence of self-neglect, including excessive consumption of alcohol and not meeting her own needs.

Ultimately, a home visit near the end of her life described Elaine’s home as *“unkempt and not fit for her to be discharged back to at this time. There is dried faeces on the carpet and receptacles around the flat with vomit in. There were also empty wine bottles around the flat.”* The same report states that Elaine does not have *“family to support cleaning the flat, her friends are in their 80's and unable to commit to supporting to clean or arrange cleaning.”* The Discharge Assessment following a Hospital admission in that year describes problems with mobility, dressing and nutrition. It also, for the first time, mentions skin integrity as a result of falls and moving around on her bottom.

Beyond the alcohol misuse and self-neglect, Elaine had a significant medical history which included: Barrett’s oesophagus[[3]](#footnote-3), gastritis, hiatus hernia, gallstones, recurrent falls, arthritis and a hip replacement. As a result, Elaine had repeated involvement with health services.

During the review period she had multiple Ambulance callouts due to having fallen when intoxicated. On the majority of occasions Elaine was appropriately conveyed to hospital for further assessment and on the occasions whereby she remained at home, Elaine was documented as having capacity to decline to travel. Ambulance Service records indicate that Elaine was never abusive and always disclosed the full extent of her alcohol intake and requested help when she needed it. Safeguarding/social care referrals were submitted. Elaine was conveyed to the Emergency Department (ED) on seven occasions and was admitted to Hospital six times.

In March 2021, a call was made to 111 by a taxi driver with concerns that Elaine was breathing heavily and appeared intoxicated. An Ambulance was dispatched, and Elaine was found in her bathroom. The crew documented *“black faeces all over the toilet and floor, flat full of empty wine bottles, mouldy cups visible and very little in the way of food”.* Elaine appeared unwell with open sores to her buttocks and feet and was “*desperately thirsty*” and drank three cups of water. She was cold, shaking and lacking in any energy and was taken to Hospital. She was discharged to a Care Home and was independent with care needs and mobile with a frame by the time she left in April 2021. A deep clean of her flat was undertaken which was funded by Elaine.

She was discharged back home with no formal support in place because Elaine did not feel she required it. She reported wanting support to bathe at home but was advised she would need to arrange this privately. Other case notes contradict this, and say that Elaine declined support. However, no assessment was undertaken and there is no evidence that an assessment of risk was carried out for her return home (although there is some evidence of risk reduction measures).

In late May 2021 she was in Hospital again but was discharged very swiftly. The notes simply state: “with no follow up”.

In June 2021, Mental Health Services found her *“in bed with a quilt loosely wrapped around her, wearing a heavily soiled hospital nightie.”* There were no sheets on the bed. There was a cup of wine on the bedside table and a number of empty wine bottles … Elaine was identified as having a: “*continued need for alcohol … poor nutritional intake, and a desire to be cared for as she is lonely and doesn’t take her prescribed medications.”* Mental Health Services removed a large quantity of unused medication and agreed to look for support for help with personal care.

In mid-June 2021, an assessment was completed by Adult Social Care, in conjunction with her GP and a Mental Health Nurse which identified eligible needs. A package of care consisting of two calls a day was sought, although Elaine said she would only accept one call a day. More specifically, she voiced a wish to move to Extra Care accommodation. This did not happen before she died and is explored in more detail below (11.3).

The rest of this report explores key themes which emerge from the last year of Elaine’s life:

* Tackling alcohol use disorders
* Mental health
* Difficulty of engagement
* Care co-ordination and multi-agency management
* Safeguarding and other Adult Social Care interventions
* Mental Capacity
* The adequacy of existing legal frameworks
* The impact of Covid-19

1. **Tackling alcohol use disorders**

Elaine had an alcohol use disorder which had a significant impact on her later life and on the problems that led to her death. By the end of her life, she was reported to be frequently drinking two bottles of wine or more per day (20 units of alcohol).[[4]](#footnote-4) She does not appear to have drunk at this level throughout her life; indeed if she had she would probably have suffered the physical health consequences far earlier in her life. However, her family indicate that she *“drank on and off over the years and would often drink too much and cause embarrassment.”* Her regular heavy drinking seems to have begun around 2015 with her increasing isolation due to problems with her hip and the ending of her platonic relationship.

Therefore, in the last years of her life Elaine is an example of someone with a “late onset” alcohol use disorder. This section considers the possible responses to the challenges and problems caused by Elaine’s drinking.

*8.1 The AUDIT tool*

Elaine’s care is a reminder of the importance of robust alcohol screening processes to ensure that alcohol-related risk is routinely and consistently identified. Without such data it will not be possible to build an appropriate response to Elaine; but it will also be harder to build a case for a general improvement in the approach to alcohol use disorders.

Therefore, in accordance with NICE Public Health Guidance 24, best practice would ensure that the AUDIT alcohol screening tool[[5]](#footnote-5) is routinely being used at assessment by all relevant professionals, whether in Primary Care, Mental Health Services, Adult Social Care, Housing or any other relevant adult service. Professionals working with the public need to be alert to the possibility of alcohol use disorders and should be routinely asking the AUDIT questions and using professional curiosity to explore, record and communicate information about this issue.

*8.2 Attitudes*

People with alcohol use disorders can often be the victims of stigma and prejudice. There is no evidence that Elaine was the victim of openly stigmatising or prejudicial attitudes. However, professionals’ beliefs can impact on the quality of care provided. The 2018 Independence Assessment states that *“Elaine is aware of the risks and chooses to continue drinking to excess.”* At other points professionals seem to readily assume that Elaine has capacity.

It is easy to believe that chronic heavy drinkers are “choosing” to behave in this way. In reality, it is unlikely that Elaine is “choosing” this lifestyle; rather, there will be a complex set of compulsions and barriers that are impacting on her behaviour. Professionals need to ensure that their beliefs about the nature of the choices that drinkers are making do not impact on care.

*8.3 Tackling alcohol use disorders: a community pathway*

Elaine had contact with the local Alcohol Service as far back as 2015. On at least one occasion there seems to have been positive engagement with the service and Elaine had an extended period of abstinence. However, in the last two years the process followed a pattern of referral, or suggestions to Elaine that she should contact the service, followed by a failure to engage.

* July 2020 - Multiple attempts made by Alcohol Services to contact Elaine to offer assessment following referral from Adult Social Care. Elaine finally answered but stated she was feeling unwell and needed to attend hospital. She advised she was not in a position to complete an assessment but would make contact when discharged from Hospital, then hung up the phone.
* August 2020 – Alcohol Services called Elaine at the Care Home to complete a triage assessment. Elaine reported she had stopped drinking and declined further support.
* September 2020 - Elaine did not want to engage with the Alcohol Services.
* November 2020 – Elaine declined input from the Alcohol Services.
* April 2021 - Referral to Alcohol Service made by Hospital Discharge Team, but Elaine did not respond to correspondence, so the referral was closed.
* June 2021 – Alcohol Services attempted to contact Elaine to undertake an assessment - no answer. The referral was closed as per agency policy following three failed attempts. Information was passed to Adult Social Care.

It is very clear that Elaine was going to struggle to work effectively with a structure that required a referral and consistent motivation to engage with services. What is surprising is that other professionals continued to expect Elaine to follow this route. For example:

* In March 2021, when Elaine does not attend, the Alcohol Services sent her a re-engagement letter.
* In May 2021, Elaine was discharged from hospital with the expectation that she would self-refer to the Alcohol Service.

This is problematic because the Alcohol Service describe themselves as a *“voluntary service (who) can only work with individuals who choose to address their substance/alcohol use.”* They have a “Did Not Attend” policy which says that following three unsuccessful attempts to engage the referral will be closed.

Individuals like Elaine, who seem to resist the help offered by services, have long been a challenge to agencies. However, a range of evidence now identifies “what works” with chronic dependent drinkers. This is most clearly summarised in Alcohol Change UK’s Blue Light project manual.[[6]](#footnote-6) However, the Office for Health Improvement and Disparities’ forthcoming clinical guidelines on alcohol, the Carol SAR from Teeswide SAB, the Alan SAR from Sunderland and other SARs also endorse the same approach.

At its core is:

* A care package centred on intensive assertive outreach.
* A multi-agency management group to guide and support the work.
* The willingness to be consistent and persistent and to allocate time to the task.

Elaine could have benefited from an assertive outreach approach which would have attempted to build a relationship with her in order to understand what lay behind this refusal of care. Is it shame about the way she is now living? Is it fear that intervention might interrupt her supply of alcohol? Is it cognitive impairment? Is it concern that she may lose her independence?

An assertive outreach approach is built on the recognition that with complex individuals such as Elaine, agencies are going to need to sustain the relationship rather than expecting her to be able to do that. This will require an approach that is:

* Assertive – using home visits
* Focused on building a relationship
* Flexible – client focused – looking at what the client wants
* Holistic – looking at the whole person
* Coordinated – linking with other agencies
* Persistent and consistent

This is resource and time intensive but can be justified by the repeated impact that Elaine was having on public services. Such a service could be based in specialist Alcohol Services.

The Practitioners’ workshop commented that: *“in Social Care we are definitely seeing alcohol becoming more of an issue with very little progression. There seems to be something missing overall with alcohol dependency that we just can't seem to get past. We can offer care and support, but what else? And so definitely [assertive outreach] is something that does need exploring.*”

These comments link across to recommendations in a previous North Yorkshire SAR – Anne.[[7]](#footnote-7) This again focused on someone with alcohol use disorders and raised questions about engagement policies. It recommended that North Yorkshire SAB “should *commission an external review of the Drug and Alcohol Recovery Service discharge process where existing concerns of substance misuse are present in-service users.”*

This is not a criticism of the Alcohol Services. Rather it is a recognition that these services have not been commissioned and developed to have the capacity to work effectively with this type of individual. Similar services in other parts of the country eg Sandwell, Northumberland, Westminster or Surrey have been designed with this capacity. It is understood that there is a current review of the service specification for local Alcohol Services, this would offer an opportunity to address this potential change.

The Alcohol Service acknowledged in its feedback that the service “may benefit from a pathway to support elderly clients (sic) whose chance of recovery is unlikely.” In a report of a Death in Service Findings Meeting, this is extended to “elderly and vulnerable clients”. It would be more appropriate for the pathway to focus on vulnerable dependent drinkers generally. The service also acknowledge that staff will need training on assessing capacity and that an end of life pathway is required.

More fundamentally with people like Elaine, all professionals need to move beyond the expectation that clients will engage with them and move towards recognising that, for this more vulnerable group, efforts will need to be made to engage them.

*8.4 Harm reduction*

If nothing else can be done with someone like Elaine, it is important that all professionals advocate and support specific alcohol related harm reduction approaches eg the importance of food and nutritional strategies or hydration. Again, Alcohol Change UK’s Blue Light project manual contains detailed guidance on this. It was positive to note that one professional warned her about the mix of codeine and alcohol and advised against this. However, this could be another specific role for the Alcohol Service and also the subject of local professional training.

*8.5 Brain damage*

With any chronic dependent drinker, it will be important to consider the possibility that cognitive damage could contribute to the challenges presented. Alcohol could have impacted on Elaine’s cognitive functioning through direct alcohol related brain damage. It is reported that she had had alcohol-related Wernicke's encephalopathy a short-term state that can be a precursor to Korsakoff’s syndrome (serious alcohol related brain damage). However, she could also have suffered cognitive damage as a result of intoxicated falls, poor nutrition, dehydration or repeated alcohol withdrawals.

It is positive to note that consideration was given to this issue. Elaine was being prescribed Pabrinex (thiamine) to protect against Wernicke Korsakoff’s syndrome. She had an MRI scan in 2018 which showed no significant damage. She had also had a number of CT scans following falls which revealed no damage. In 2020 the Mental Health Trust explored this issue and a cognitive impairment test put her functioning in the normal range. There were plans for further testing, but this came to nothing because Elaine failed to engage with the process.

However, this is a reminder of the importance of considering cognitive functioning with drinkers, especially those that services find hard to engage.



* 1. *Tackling alcohol use disorders: residential rehabilitation*

The ideal care pathway for Elaine would probably have been inpatient detoxification followed by a period of residential care/rehabilitation in a “dry environment”. Dame Carol Black’s *Review of drugs part two: prevention, treatment, and recovery* (states)*: “Local commissioning of inpatient detoxification and residential rehabilitation has decreased substantially in recent years, despite evidence of their effectiveness and importance for people with particularly complex needs.”*



Such a placement would have enabled:

* A time away from her isolated home situation in a protective environment.
* A chance to properly assess her physical health and any possible cognitive impairment.
* The opportunity to address her alcohol use disorders and develop an appropriate long-term care plan.

If Elaine had been significantly younger, she could have been a candidate for a specialist residential alcohol rehabilitation facility. This would probably not have been a local unit and could have been anywhere across the country. However, it is unclear whether there would have been an appropriate specialist facility for someone of her age and with her physical vulnerability. As a result, this issue of residential care is dealt with in the more general section below on her care after April 2021 (section 11.3).

1. **Mental Health**

*9.1 General*

Elaine had diagnosed mental disorders in addition to her alcohol use disorders. These problems were identified as far back as the 1960s when Elaine was in her twenties. She also reported an episode of depression 30 years before her death. She was treated with ECT and stated that her mental state improved dramatically. In addition, she identified longstanding issues with anxiety.

In the last ten years of her life, she was continually in contact with Mental Health Services and was diagnosed with depression, anxiety and emotionally unstable personality disorder (EUPD). She described how, when she was anxious, she became breathless. However, in particular, Elaine had a pattern of self-harm/suicidality.

*9.2 Suicidality*

Elaine acknowledged that: “*I have…tried to end my life by taking overdoses on several occasions.”*

In 2014, she had an inpatient psychiatric admission. This is presented as an example of both her suicidality and how quickly her mood could change: “*She had been expecting a friend for dinner, but the friend didn’t show up. Elaine’s immediate response was to slit her wrists (rather than using coping strategies).”*

In 2015 there were several medical admissions for overdose. The notes state that: “*Sometimes she was discharged home, sometimes referred to the Crisis Team, sometimes she was admitted to psychiatric inpatients for a lengthy period. Sometimes she would go out on leave and be brought back by the Police.”*

However, there is evidence that after 2015 she began to drink more heavily and that the main focus of her problems was her alcohol use and consequent self-neglect and physical decline. For example, the Police identified that they saw a decline in public safety welfare calls to Elaine after 2015. Previously there had been repeated callouts associated with her mental distress. Therefore, this theme does not feature significantly in this report covering the last year of her life.

* 1. *Emotional Unstable Personality Disorder (EUPD) pathway*

Because of her diagnosis of personality disorder, Elaine was reported to be on the local EUPD pathway. However, this was described as more of a technicality than a reality. It was explained that much of the pathway relies on self-led techniques. There is a toolkit of therapies and skills that help people learn from a trauma informed care approach and help people to overcome crisis and contain distress. However, these pathways require a lot of hard work around self-management and changing identity and, perhaps inevitably, Elaine appeared to struggle with that. This does raise questions about the appropriateness of the pathway for people like Elaine and whether alternative approaches are required for clients that services find more difficult to engage.

She was also prescribed Olanzapine from 2014 onwards. This is an anti-psychotic but can also be used to help with the psychic distress experienced by people with EUPD. It also helps to stabilise mood alongside an antidepressant. However, she did have periods where she would stop taking her Olanzapine (see next section).

*9.4 Medication management*

Elaine’s management of her psychoactive medication was an ongoing concern for practitioners. In 2021, it was apparent from the medications in her property that she had been “cherry picking” medication, despite having a good understanding of what each medication was for. At one point, the Mental Health team took away almost 60 boxes of unused medication. When this was discussed with Elaine, she stated that *“she did not like taking them as she knows she shouldn't drink alcohol with them.”* As a result, a plan was put in place to manage her medication use. This was complex for agency staff caring for her because of the risk of prompting her to take a drug when she was intoxicated. Therefore, it was suggested that Agency staff monitor medication intake only, by checking how often medication is being taken and then reporting back to the prescriber. This only began near the end of her life so its impact is unclear.

1. **Difficulty of Engagement – the need for a policy**

*10.1 Overview*

The key challenge with many clients is not that they have an alcohol use disorder or a mental health disorder or a physical health problem. The concern is that they are difficult to engage into the care they need for those problems. Elaine had various aspects to her presentation – her alcohol use disorders, mental health concerns, health issues and self-neglect. However, one issue underpinned all of these: she was very reluctant to engage with services.

Throughout the notes there are repeated examples of these challenges:

* History of being unresponsive to services and interventions/not answering the door or telephone calls.
* Mental health charity notified the GP that the patient had disengaged.
* Elaine was discharged from the Dietician due to no contact from their opt in letter.
* Elaine’s engagement with Adult Social Care was intermittent: she initially declined a visit and was rude to the worker who visited to complete a welfare check.
* Elaine failed to attend an appointment with Mental Health Services and in light of her not engaging the referral was closed. A Social Care Worker attempted to call Elaine, no answer. It was noted that without very regular efforts to engage Elaine she disengaged.
* She refused a blood test for a Dementia screen.
* She consistently failed to engage with the Alcohol Services.
* A Physiotherapist called to tell her she will be visiting. Elaine was slurred of speech on the phone and declined the visit.
* Care Support Worker ... “*Went to the property difficult to gain access. Elaine became irritable and confrontational… declining any input*.”

Engagement is the fuel on which any care process runs. Without client engagement care cannot progress. The impression is that agencies continued to attempt to engage with Elaine in the same way: making an appointment, turning up or calling and hoping she will accept contact this time. This seems to be a case of “professional optimism” triumphing over the need for a more “professionally curious” approach.

Elaine is not unusual in presenting difficulties of engagement. The Manchester Safeguarding Partnership *Carers Thematic Learning Review 2021* describes: *The challenges of supporting adults who do not consent to treatment or support and who are judged to have the capacity to make those decisions in an informed way.*  The review goes on to comment on: “*a sense that their persistent refusal of offers of care and support were perhaps too readily accepted, perceived and interpreted by practitioners as ‘non-compliance’ rather than as a form of self-neglect, which was a product of the adults’ adverse life experiences, poor quality of life and very challenging day to day living*.”

Another review from Manchester, the *Homelessness Thematic Review,* comments that: “*When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person’s refusal to engage; loss and trauma often lie behind refusals to engage. Contact should be maintained rather than the case closed, in an effort to build up trust and continuity.”*

*10.2 A policy on client engagement*

Elaine highlights the need for individual professionals to have a specific focus on engagement. However, at the organisational level, it highlights the need for a published, multi-agency procedure to guide professionals in dealing with client non-engagement. To make that procedure useful it will need to provide guidance on:

* how to judge the level of risk or vulnerability that warrants ongoing, assertive action;
* how to practically intervene with hard to engage clients; and
* how to escalate these concerns and where they should be escalated to.

It will need to cover themes including:

* Multi-agency management
* Care coordination
* Assertive outreach
* Guidance on engagement techniques

These are explored over the next four sections of the report. The Mental Health Trust reported that they already have a policy on non-engagement which could inform the development of a multi-agency policy.

*10.3 Multi-agency management*

It is clear that there was interagency working around Elaine. For example, in June 2021 she was discussed in the HARA Huddle meeting - (a joint ASC and Health meeting). Nonetheless, the SAR referral comments that a chronology following her death found that Elaine had input from many agencies: *“However, there was limited evidence of a coordinated response ... There were numerous indicators of risk that were not escalated in a joined up approach over the past year of her life.”*

Elaine’s care would have benefited from escalation to a regular multi-agency forum involving Emergency Services, Health, Mental Health, Drug & Alcohol Services, Adult Social Care and Housing Services, among others[[8]](#footnote-8). This group could have ensured:

* Information was shared
* Points of disagreement could be debated
* A jointly owned plan was developed
* Agencies were challenged to try different approaches
* Work continued until Elaine’s behaviour allowed her to engage positively with services

A regular multi-agency framework would also have facilitated agencies identifying the deterioration in her wellbeing in the last months of her life.

North Yorkshire could benefit from having a standing specialist multi-agency group that focuses on complex and difficult to engage individuals. This would provide a structured alternative to ad hoc meetings. This approach has worked well with people with alcohol use disorders in other areas eg Sandwell, Northumberland. This group would also provide a focus for expertise on working with a very challenging group.

The Acute Trust acknowledges the need for work related to this theme. They propose that:

* A member of the Trust Adult Safeguarding Team attends the Emergency Department frequent attenders meeting; and
* The Trust Adult Safeguarding Team undertake a project on supporting patients who self-neglect with a Multi-Disciplinary Team approach.

*10.4 Care Co-ordination*

The Primary Care summary report says that: “*There appeared to be a lot of health professionals and other professionals involved with Elaine's care, but it is not clear from the GP records how this care was co-ordinated, who was leading it, what meetings were taking place across agencies and whether adult safeguarding were involved or whether there was a “risk” plan for Elaine.”*

Similar to what has been said about multi-agency management, many agencies and professionals were in contact with Elaine, yet no one person seems to have taken on a care coordination role with her.

Her care would have benefited from clear leadership: a care coordinator as well as multi-agency management. These two elements would have fed off each other:

* having a care coordinator would have supported regular multi-agency meetings and supported focused discussions within those meetings, and
* regular meetings could equally have driven the appointment of a care coordinator.

*10.5 Assertive outreach*

This approach would also have been more powerful if it was supported by assertive outreach. This has been commented on already in section 8.3. The same comments apply in this section. It would be useful to have the commissioned capacity to provide this approach not just to people with alcohol use disorders but to all self-neglecting individuals that services find difficult to engage.

*10.6 Understanding engagement techniques*

This whole process would also benefit from guidance on what techniques work with hard to engage clients. This is an under-developed field. The SAR author looked for national guidance on this issue as part of the drafting of this report but could not find an overarching guidance document. Reports such as “The Keys to Engagement” (mental health)[[9]](#footnote-9) and “The Blue Light Project” (alcohol misuse)[[10]](#footnote-10) have addressed this issue with specific client groups but there is no single guidance document. Whether at a local or a national level, such guidance will be a vital support to those working with vulnerable and difficult to engage clients.

1. **Safeguarding and other Adult Social Care interventions**

*11.1 Safeguarding Concerns*

Elaine was an adult with care and support needs and three safeguarding concerns were raised about her during the relatively brief review period.

* July 2020 – A welfare check was undertaken because of a lack of contact. She was found surrounded by wine bottles and clearly unwell. An Ambulance was called, and Elaine was admitted to hospital. A safeguarding concern was raised by the Living Well Team due to conditions at home and lack of engagement. This safeguarding progressed and in September 2020 the Safeguarding Coordinator agreed closure because: *“…she is now in a situation where her health is improving and she is able to recognise that she requires ongoing support around her alcohol dependency. It is also encouraging that she recognised that she needed medical input…showing she has a degree of functional insight into her need for support. She is now willing to engage with the Alcohol Service, who are due to make contact with her at the Care Home, and staff (there) are supporting her with other areas of her wellbeing.*’
* March 2021 – An Ambulance crew found Elaine in the bathroom and there were *“black faeces all over the toilet and floor, flat full of empty wine bottles, mouldy cups visible and very little in the way of food…Elaine appeared unwell with open sores to her buttocks and feet and was “desperately thirsty” and drank 3 cups of water. Elaine was cold, shaking and lacking in any energy and was taken to … Hospital ... Crew completed a safeguarding referral.”*
* June 2021 – An Ambulance attended and found Elaine sitting in her living area and able to mobilise independently with no injuries. The crew documented that Elaine advised that the lift to her flat no longer worked and that she was worried she was going to be evicted. Elaine was taken to Hospital and the crew submitted a safeguarding referral.

However, there were also a larger number of missed opportunities to raise safeguarding concerns. In particular there is a pattern of the Hospital not completing concerns: this is primarily associated with the Emergency Department (ED). For example:

* In July 2020, Elaine was brought in by Ambulance due to alcohol intoxication, the Adult Safeguarding referral section of the ED notes was not completed.
* In August 2020, Elaine again arrived at Hospital by Ambulance following a call which highlighted self-neglect, the Adult Safeguarding section of the notes was not completed.
* In March 2021, a safeguarding referral form was started by a member of the nursing staff in the ED. Unfortunately, the referral was not completed and not submitted.
* In May 2021, the Acute Trust documented that a “safeguarding was submitted from ED”, but there is no record of this taking place.

This happens again at least twice in May 2021. The Acute Trust notes that *“There was an assumption on numerous occasions that a safeguarding referral had been sent from the Emergency Department.* No other Hospital team raised safeguarding concerns for Elaine, perhaps because there was an assumption that it had already been done.

However, other agencies also missed opportunities to raise safeguarding concerns.

* At least two of the above Hospital attendances involved Ambulance call outs. In August 2020, Elaine made a call to 999 stating she was “very ill and an alcoholic”. The Ambulance crew attended and documented that *Elaine had no recollection of waking that morning and had called her friend as she felt unwell and was afraid of living. Limited food in the fridge and signs of self-neglect documented by crew.* Elaine was taken to Hospital for assessment, but no safeguarding concern was submitted.
* In early 2021, Elaine was found on the floor by the Fire Service. She was left with Ambulance staff but neither agency submitted a safeguarding referral.
* The SAR referral (from Adult Social Care) identifies that in December 2020 Elaine reported using codeine to manage her emotional well-being and that this was a missed opportunity to complete an assessment and raise a safeguarding concern.

The Acute Trust had previously been mentioned in the completed Kirklees SAR for Adult N[[11]](#footnote-11) with reference to safeguarding referrals not being sent. Adult N attended Hospital on 22 occasions, presenting in drink and with signs of self-neglect. Safeguarding referrals were not considered. The Acute Trust acknowledge the need to remind teams to complete a safeguarding referral if they have concerns about a patient even if they think others may have already submitted one.

The Anne SAR for North Yorkshire SAB recognises that this is a concern beyond the Acute Trust. It recommends that “*NYSAB are required to raise awareness across the Safeguarding Partnership of the requirement of when to raise a safeguarding concern as detailed within the Joint Safeguarding Adults Multi Agency Policies and Procedures, West, North Yorkshire, and York.” [[12]](#footnote-12)* This same recommendation seems appropriate in the light of this current SAR.

*11.2 The risk of exploitation*

Elaine’s relative social isolation, dependence on others to access her daily living needs, her physical frailty and alcohol use did place her at risk of exploitation and abuse. Her family has suggested that she faced financial abuse from two sources:

* Taxi drivers who were being asked to buy alcohol for her; and
* A man with whom she had had a sexual relationship a long time previously but who remained in contact. (It is important to note that this was not anyone who is identified elsewhere in this report.) No further information was identified as to whether this was occurring during or just prior to the review period. Therefore, no comments are made.

Her family said that Elaine was known to request that taxi drivers buy her alcohol. She gave them her bank card to draw money out of the bank then they brought it back with the alcohol. Elaine was advised not to do this, and her family contacted one company who did stop supplying her. Elaine herself expressed concern that professionals should not tell her family about her use of taxis in case they put a stop to it.

However, none of the professionals were aware of either of these situations leading to financial abuse. It was commented that one taxi company Elaine used had a good reputation for doing shopping for people with mobility problems. It is also worth noting that in March 2021 a taxi driver called 111 with concerns that Elaine was breathing heavily and appeared in drink.

As a result no comments or recommendations are made about her use of taxis, but it has been included in case this emerges as a pattern in other safeguarding work in North Yorkshire.

*11.3 The discharge in April 2021*

In both 2016 and 2018 Elaine had Acute Hospital admissions. On both occasions there were discussions about whether she needed some form of residential care. In 2016, Elaine herself showed interest in this possibility. In 2018, her family suggested she should be in residential care, but Elaine was not in agreement.

In August 2020, Elaine was admitted to hospital due to being unwell and reporting suicidal feelings. A safeguarding concern was raised at this point (see above). The hospital discharge note reads *“Alcoholism, Arthritis, Hip replacement, depression … Known to mental health services for last decade”*. She then had a short stay in a Care Home and was discharged back home on the basis that Elaine would be assessed by a Physiotherapist and Occupational Therapist while in the Care Home. The safeguarding was closed.

However, by October/November 2020, Elaine was drinking again, and her self-neglect continued and in March 2021, a similar incident occurred. She was admitted to Hospital as a result of failure to thrive, hypothermia, metabolic acidosis, excess alcohol and withdrawal. This appears to be a pivotal point in her care. Following the March 2021 Hospital admission, Elaine was readmitted to the Care Home. It is noted in the discharge assessment that: *“Elaine agreed to transfer to a residential Interim Placement for a period of further assessment, she is aware this is temporary until her flat has been deep cleaned. At this time she needs support of one person with all daily tasks.”* However, she was then discharged back home with no formal support in place.

Elaine raised concerns about returning home, and it is noted that her family thought she should move into a Care Home permanently. Elaine herself expressed interest in an Extra Care facility in the area. She was advised by an Adult Social Care worker that she did not meet the eligibility for a Care Home. However, this conversation is not recorded in the notes. Therefore, there is no rationale for the view that Elaine would not have needs that were eligible for support under the Care Act.

Elaine reported wanting support to bathe at home and with shopping but was advised she would need to arrange this privately. Other case notes contradict this, and state Elaine declined support. No assessment was undertaken. Adult Social Care commented in the SAR referral that *“Given the history of evidence that Elaine [was] not able to meet her own needs at home, eligible needs were evident and reablement could have been considered to reduce risks… No evidence that an assessment of risk was carried out for return home although some evidence of risk reduction measures.”*

Some follow up is carried out by Adult Social Care. However, Elaine began drinking again on her return home. It is reported that there were *“numerous failed attempts to make contact.”* When contact is established with Elaine, she is *“inconsistent in her stated desired outcomes - changes her mind about the application to Extra Care Housing.”* It is noted by Adult Social Care that *“there is a quick deterioration and no Care Act assessment is completed once home (should at least have been completed to support application to Extra Care Housing)”*.

Later in May, and in June, there were two further Ambulance call outs due to falls, at least one of which is acknowledged to be the result of intoxication. After the latter incident, the crew completed a safeguarding referral to express their concerns.

In June 2021, a Care Act assessment was completed. Elaine was identified as having eligible needs and was assessed as requiring twice daily support with nutrition, hydration and maintaining her home. At that point she would only accept one daily care visit. Consideration then began to be given to Residential Care or Extra Care. Elaine was in agreement with this, and the view was that this would curtail her drinking and improve her mental health. She said that *“I will not drink when I am in an Extra Care facility. I didn't want to drink when in Residential Care. I just find being at home alone difficult.”* This does seem to be supported by the experience of the previous fifteen months*.*

However, for this to be arranged Elaine would have required a detoxification and it was not immediately obvious how this could be arranged, particularly to dovetail with entry into the Extra Care facility. Ultimately, none of this happened because within the month Elaine had died. It is impossible to say whether such a move would have prevented her death, but it would have ensured a more dignified end of life and reduced the trauma for her family.

The Council acknowledge that there are lessons to be learned from Elaine’s care. They identify the need for:

* *A better understanding of working with people at risk of self-neglect. There was a significant history that should have been considered when the opportunity arose to plan her support when she was engaging with services. There were numerous indicators of risk that were not escalated over the past year of her life. The Practice Team will take an action from this to do a Countywide CPD session on working with people who are at risk of self-neglect. (This case can be used as a case study. The safeguarding team are currently reviewing the Practice Guidance for self-neglect so this can feed into this work.*
* *(Emphasising) the importance of completing a Care Act assessment to evidence eligibility and to record our rationale for decisions made. This also feeds into the self-neglect work above around eligibility/assessing mental capacity and self-neglect.*

1. **Using the Mental Capacity Act**

The agency reports mention Elaine’s mental capacity at several points. The prevailing view seemed to be that she had the mental capacity to (presumably) care for herself.

* In 2018, a Council Independence Assessment Report described Elaine as having capacity to make all decisions for herself.
* In 2020 another Council Independence Report said that Elaine had capacity for all decision making. *“She is aware of risks even if sometimes she chooses to make what others may consider unwise decisions.”*
* In August 2020 Elaine entered a Care Home after discharge from hospital to “improve mobility and to have stair practice”. She is stated to have capacity and is ultimately discharged home.
* In June 2021, Elaine’s GP states that she appeared to have capacity and was aware of indications for her medication.

Practitioners repeatedly comment on the clarity of Elaine’s comments about her situation: *“Elaine was never abusive and always disclosed the full extent of her alcohol intake and requested help when she needed it.”* Elaine herself said: *I drink a lot to deal with my issues - approximately two bottles of wine a day. I then start to neglect myself in terms of personal care and nutrition.*

These comments and presentations seemed to suggest to practitioners that Elaine had capacity. However, consideration needs to be given to all four criteria in the Mental Capacity Test. Elaine may understand and retain information about her problems. She may be able to communicate decisions. What she does not seem to be able to do is to use or weigh information. She does not take the steps that she recognises are required to protect herself eg to eat, stay hydrated, maintain her hygiene. Almost certainly she fails to do this because of the compulsion associated with alcohol dependency. This concept is specifically acknowledged in section 4.22 of the current Code of Practice on the Mental Capacity Act.

In particular, this situation highlights the importance of considering executive capacity. Primary Care comments that: “*there is no formal mental capacity assessment documented in the health records … unsure whether professionals considered executive functioning.”*

In assessing capacity with vulnerable and self-neglecting individuals like Elaine it is important to consider executive function/executive capacity. The Teeswide Carol SAR (about a chronic dependent drinker) talks about the need to look at someone’s “executive capacity” as well as their “decisional capacity”. Can someone both *make* a decision and *put it into effect* (ie use information)?

This will necessitate a longer-term view when assessing capacity with someone like Elaine. Repeated refusals of care, as happened with her, should raise questions about the ability to *execute* decisions. The draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function as well as considering repeated failed decisions when assessing capacity.

Again, the lack of a clear multi-agency framework and clear leadership around Elaine’s care would have hindered the use of the Mental Capacity Act. Within a multi-agency meeting, professionals could have considered her mental capacity from a number of angles and have professionally challenged situations in which they felt that the approach was inappropriate.

Ultimately, even if it is argued that Elaine is capacitated, this should not be the end of her care. *The 2013 Mental Capacity Act 2005: Post-Legislative Scrutiny* report, criticises the use of the Act in this way: *The presumption of capacity…is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm.*[[13]](#footnote-13) The MCA Code of Practice repeatedly highlights the need to assist capacitous people with their decision making[[14]](#footnote-14) or to undertake *further investigation in such circumstances.*[[15]](#footnote-15)

1. **The adequacy of existing legal frameworks**

Elaine highlights problems with the existing legal frameworks for managing people with chronic alcohol use disorders. Both the Care Act and the Mental Capacity Act highlight the importance of individual’s having the right to self-determine, eg

* The importance of beginning with the assumption that the individual is best-placed to judge the individual’s well-being (Care Act).
* The importance of the individual participating as fully as possible in decisions (Care Act).
* A person is not to be treated as unable to make a decision merely because she makes an unwise decision (MCA).

However, this prioritisation is very challenging to negotiate when someone’s alcohol use disorder and related choices constantly place them at very serious risk of harm; and, moreover, when they appear to be repeatedly choosing to return to that lifestyle (and repeatedly articulating that choice).

The challenges posed by this situation are even greater when one turns to the guidance on the legislation:

* The current Code of Practice on the Mental Capacity Act mentions alcohol just three times.
* The Guidance on the Care Act mentions alcohol just twice.

Practitioners are working in the absence of any clear statutory guidance on how to negotiate the type of challenges posed by Elaine. This is not an isolated issue, 25% of SARs feature people with significant alcohol use disorders.[[16]](#footnote-16) This does raise the question of whether England needs a new legislative framework for managing chronic dependent drinkers?

Other western countries do have legislation which is specific to this client group and allows the compelled, protective, detention of dependent drinkers like Elaine. In some jurisdictions this is called “civil commitment” (eg USA). [[17]](#footnote-17) [[18]](#footnote-18) [[19]](#footnote-19) Indeed Article 5 of the European Convention on Human Rights specifically recognises this possibility.[[20]](#footnote-20) Such legislation might have provided a framework within which Elaine’s needs could have been managed.

Three options exist for addressing this gap:

* Revised guidance/code of practice or specific guidance as per the CQC guidance on the Mental Health Act & Eating Disorders
* Revisions to the existing legislation
* New legislation as per other countries

In the short term, it is most realistic to look for a change to the guidance on the legislation. In particular, clarification about how the Mental Capacity Act and the Care Act should be applied to this client group including case study examples. This would cover issues such as “executive capacity” or how the self-neglect provisions of the Care Act apply to dependent drinkers.

The Safeguarding Adults Board may want to consider pressing national government, at the least, for better guidance on how to use the existing legislation most effectively with this client group.

1. **Additional point - Covid 19**

The entirety of the period under review was during the Covid-19 restrictions. This is likely to have had an impact on Elaine’s care. It would also have been harder to have pursued an assertive outreach or other community approach in this period. This needs to be acknowledged when considering Elaine’s care. However, it is not possible to draw a direct line between the Covid restrictions and Elaine’s death. Indeed her family commented that although Covid made Elaine more isolated, in reality her life was now much more like everybody else’s, because they were also isolated. As a result, no comments have been made on Covid’s impact.

1. **Key Learning Points**

The latter years of Elaine’s life were significantly impacted by her heavy drinking. As a result, the attempts to care for her provide some key learning about the management of alcohol use disorders:

* It is important that professionals use standardised alcohol screening tools. In particular, following NICE Public Health Guidance 24, the AUDIT alcohol screening tool should be widely used by all frontline professionals to provide a consistent means of identifying and communicating information about alcohol-related harm.
* Professionals need to move away from the view that people like Elaine are choosing this lifestyle. In reality, they are at the centre of a complex storm of compulsions and physical and emotional barriers to change.
* In particular, professionals need to be realistic about referral pathways for people with alcohol use disorders. The idea that Elaine was simply going to self-refer to, and then engage with, the Alcohol Service was repeated by a number of workers. That is simply not going to work with a more complex client like her: she is going to need a far more robust pathway to support her into treatment services.
* This will need to be matched by Alcohol Services that are commissioned to provide more assertive/harm reduction approaches to drinkers who are proving difficult to engage into services.
* Elaine is also a reminder of the importance of considering the possibility of cognitive impairment with drinkers.
* Ultimately the best pathway for Elaine would probably have been an inpatient detoxification followed by residential care. This approach was being considered with her but does not seem to have come to anything. However, Elaine is a reminder of the importance of residential pathways with people with alcohol use disorders.

Although alcohol is a major feature of the last years of Elaine’s life it is not the only issue. There are also concerns about her physical and mental health. However, one issue underpins all of these issues – she is very reluctant to engage with services. The key challenge with many clients is not that they have an alcohol use disorder or a mental disorder or a physical health problem. The problem is that services find them difficult to engage into the care that they need.

This difficulty of engagement can easily be dismissed as a function of her various other problems but it requires a focus in its own right. If professionals cannot engage Elaine, they will not be able to help her.

* This highlights the need for a published, multi-agency procedure to guide professionals in dealing with client non-engagement. To make that procedure useful it will need to provide guidance on:
* how to judge the level of risk or vulnerability that warrants ongoing, assertive action;
* how to practically intervene with people that services find hard to engage; and
* how to escalate these concerns and where they should be escalated to.
* Elaine’s care would have benefited from escalation to regular multi-agency discussion involving Emergency Services, Health, Mental Health, Drug & Alcohol Services, Adult Social Care and Housing Services, among others.[[21]](#footnote-21) This group could have ensured: information sharing, a jointly owned plan and supported ongoing work to engage Elaine with services. It could also have helped to identify the deterioration in her well-being in the last months of her life.
* North Yorkshire could benefit from having a standing specialist multi-agency group that focuses on vulnerable and difficult to engage individuals. This would provide a standing, expert group for managing this client group rather than requiring ad hoc meetings.
* Her care would have benefited from clear leadership: a care coordinator as well as multi-agency management.
* As was earlier highlighted with alcohol, the approach to Elaine would have been more powerful if it was supported by assertive outreach. Elaine needs someone to work with her and build a relationship with her not to simply do things to her or for her.
* This whole process would also benefit from guidance on what techniques work with individuals that services find hard to engage. This is an under-developed field. Whether at a local or a national level, such guidance will be a vital support to those working with vulnerable and difficult to engage clients.

Elaine was an adult with care and support needs and the Care Act provides a framework for addressing some of the challenges she posed, as well as protecting her from further harm. It is positive to note that three safeguarding concerns were raised about her during the relatively brief review period. However, there were also a larger number of missed opportunities to raise safeguarding concerns.

* There is a particular pattern of the Acute Trust not submitting concerns – this is primarily associated with the Emergency Department. A similar pattern was identified in a previous SAR – Adult N. This clearly indicates an area for action.
* The Acute Trust acknowledge the need to remind teams to complete a safeguarding referral if they have concerns about a patient even if they think others may have already submitted one.
* Other agencies also missed opportunities to raise safeguarding concerns which does suggest another area for action, reminding all professionals of the importance of raising safeguarding concerns, including about people with patterns of alcohol related harm.

A pivotal point in Elaine’s care was her admission to hospital in March 2021 and her subsequent discharge. Following this admission, Elaine was readmitted to a Care Home that she had been in the previous year. However, she was then discharged back home with no formal support in place. Elaine raised concerns about returning home, and her family thought she should be in a care home. Elaine herself expressed interest in an Extra Care housing scheme in the area. However, there appeared to be some confusion about eligibility, the support Elaine wanted and whether Elaine actually wanted to move into care. As a result, Elaine was left at home and deteriorated very swiftly toward her death in July 2021.

Adult Social Care have been commendably open about this incident and have highlighted two key learning points:

* Adult Social Care staff need a greater understanding of working with people at risk of self-neglect particularly as a result of alcohol and drug use. There was a significant history that should have been considered when the opportunity arose to plan her support when she was engaging with services. There were numerous indicators of risk that were not escalated in a joined-up approach over the last year of her life.
* The importance of completing a Care Act assessment to evidence eligibility and to record the rationale for decisions made.

As a result, Adult Social Care are running a Countywide CPD session on working with people who are at risk of self-neglect. The Practice Guidance for self-neglect is also being reviewed.

The agency reports mention Elaine’s mental capacity at several points. The prevailing view seemed to be that she had the mental capacity to care for herself. However, Primary Care comments that: “*there is no formal mental capacity assessment documented in the health records…unsure whether professionals considered executive functioning.”*

In assessing capacity with vulnerable and self-neglecting individuals like Elaine it is important to consider executive function. Can someone both *make* a decision and *put it into effect* (ie execute the decision)? The draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function and to consider repeated failed decisions when assessing capacity.

* This suggests that training is required on the consideration of executive capacity with people with health and social care needs generally and with dependent drinkers specifically.

1. **Good practice**

Many agencies made efforts to help Elaine. Most professionals appear to have worked appropriately with her within the framework of their individual disciplines. In particular, much of the work undertaken with her was during the period of the Covid-19 restrictions and it is clear that agencies continued to work and maintain services during that difficult period.

However, specific points of good practice did emerge:

* Elaine was being prescribed Pabrinex which is a vitamin (thiamine) injection given to drinkers to reduce the cognitive damage that results from chronic heavy drinking.
* Elaine’s sister was very complimentary about the worker in the Adult Social Care Living Well team who regularly updated her about her sister. Elaine also spoke positively about this worker.
* At the needs assessment in June 2021, a worker says that staff should encourage Elaine to drink water at each visit. This is a very simple point but a very sensible step with chronic drinkers and highlights the importance of harm reduction approaches.

1. **Recommendations**

**Recommendation A**

North Yorkshire’s Safeguarding Adults Board should ensure that all frontline services are aware of, and are able to use, robust alcohol screening tools such as the AUDIT tool to identify and record the level of substance related risk for clients.

**Recommendation B**

The Director of Public Health, as part of work on the new substance use strategy, should review whether the specific needs and impacts of chronic, change resistant and dependent drinkers are identified in needs assessments and addressed in any future commissioning plans. In particular, investment in assertive outreach capacity for this group of clients should be considered locally.

**Recommendation C**

The Safeguarding Adult Board should undertake a programme of work that supports professionals to move away from the view that people like Elaine are choosing this lifestyle and to recognise that they are at the centre of a complex storm of compulsions and physical and emotional barriers to change, including potentially cognitive impairment.

**Recommendation D**

North Yorkshire SAB should lead the development of local procedures that guide professionals on how to respond to individuals requiring safeguarding but whom agencies find difficult to engage. (These protocols could equally apply to vulnerable clients outside of the safeguarding context.)

**Recommendation E**

North Yorkshire SAB should ensure that those procedures include the option of care coordination and the need to escalate the more vulnerable, hard to engage clients, to a local multi-agency forum for joint management. The SAB should ensure that the importance of escalating concerns about more vulnerable clients is cascaded as widely as possible through their own and partner agency communication systems.

**Recommendation F**

North Yorkshire SAB should ensure that there is ongoing training and messaging about the need to raise safeguarding concerns about vulnerable individuals and those with alcohol use disorders in particular; and that, within Adult Social Care and other relevant agencies, practitioners are able to identify self-neglect concerns through effective triage and recognise when those concerns require a multi-agency safeguarding meeting under s42(2)

**Recommendation G**

North Yorkshire SAB should ensure that guidance or protocols are available to support professionals to consider the use of the Mental Capacity Act in the context of clients that agencies find difficult to engage generally and people with alcohol use disorders specifically. This should include reminders about the importance of considering executive capacity.



**Recommendation H**

North Yorkshire SAB should ensure that Adult Social Care and relevant partner agencies:

* run a Countywide CPD session on working with people who are at risk of self-neglect;
* review the Practice Guidance for self-neglect; and
* emphasise the importance of completing a Care Act assessment to evidence eligibility and to record the rationale for decisions made.

**Recommendation I**

North Yorkshire SAB should work with the local Acute Trust to address the repeated pattern of Hospital staff not completing safeguarding concerns. A similar pattern was identified in a previous SAR – Adult N. The Acute Trust needs to ensure teams complete a safeguarding referral if they have concerns about a patient even if they think others may have already submitted one. The SAB should also ensure that all relevant partner agencies are reminded of this message.

**Appendix 1 Terms of reference**

* Do our current recording systems meet the needs of clients like Elaine?
* How effective was the communication between agencies during the period under review and were there any missed opportunities for information sharing?
* How effectively were Elaine’s medication needs managed given the number of prescribers and known non-concordance? Who should have/had overall control of medications?
* How effectively did the HAS teams work together to meet Elaine’s needs and manage risk – discharge hub, discharge pathway, Living Well team, and Community Assessment team
* To what degree were Primary Care informed of the circumstances regarding Elaine, and how effective was their involvement?
* Were there any omissions in the skills and knowledge of practitioners with regards to working with people who self-neglect but are deemed to have capacity to understand the risks?
* How accurate and effective was the advice given to front-line staff regarding alcohol & substance misuse during the period?
* How effective was the safeguarding response, and did it take into consideration the particular risks associated with self-neglect?
* How do we ensure an organisation takes the lead for the person and is responsible for ensuring care/needs are brought together and who should that be?
* To what extent was alcohol dependency viewed as a form of self-harm or self-neglect (and could ageist assumptions have influenced this).
* Were there any areas of good practice?



1. Elaine is a pseudonym [↑](#footnote-ref-1)
2. The practice of the key doctor involved in this process has been subject to investigation and action. [↑](#footnote-ref-2)
3. Abnormal change of the cells present in the lower portion of the oesophagus due to acid reflux, which causes the lining to thicken and become inflamed. [↑](#footnote-ref-3)
4. The recommended safe drinking guidance is 14 units per week. [↑](#footnote-ref-4)
5. [Alcohol Use Disorders Identification Test (AUDIT) (auditscreen.org)](https://auditscreen.org/#:~:text=The%20AUDIT%20%28Alcohol%20Use%20Disorders%20Identification%20Test%29%20is,alcohol%20screening%20instrument%20since%20its%20publication%20in%201989.) [↑](#footnote-ref-5)
6. For transparency purposes it should be noted that the author of this report is the co-author of the Blue Light project manual. [↑](#footnote-ref-6)
7. [NYSAB (safeguardingadults.co.uk)](https://safeguardingadults.co.uk/learning-research/sar-anne/) [↑](#footnote-ref-7)
8. Police and Community Safety could also be regular members of such a group, albeit less relevant for Elaine.

   [↑](#footnote-ref-8)
9. <https://www.centreformentalhealth.org.uk/sites/default/files/keys_to_engagement.pdf> [↑](#footnote-ref-9)
10. <https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project> [↑](#footnote-ref-10)
11. [Adult N: A Safeguarding Adult Review (kirklees.gov.uk)](https://www.kirklees.gov.uk/beta/adult-social-care-providers/pdf/ksab-adult-n-report.pdf) [↑](#footnote-ref-11)
12. ['Anne' - Safeguarding Adult Review (NYSAB)](https://safeguardingadults.co.uk/learning-research/sar-anne/) [↑](#footnote-ref-12)
13. Mental Capacity Act 2005: Post-Legislative Scrutiny 2013 105 [↑](#footnote-ref-13)
14. Mental Capacity Act 2005: *Code of Practice 1.2* [↑](#footnote-ref-14)
15. Mental Capacity Act 2005: *Code of Practice 2.11* [↑](#footnote-ref-15)
16. Preston-Shoot M. et al. - National SAR Analysis: April 2017-March 2019 – LGA/ADSS (2020) [↑](#footnote-ref-16)
17. <http://www.emcdda.europa.eu/attachements.cfm/att_142550_EN_SE-NR2010.pdf> [↑](#footnote-ref-17)
18. <http://www.legislation.govt.nz/act/public/2017/0004/latest/DLM6609057.html?search=ts_act%40bill%40regulation%40deemedreg_substance+addiction_resel_25_a&p=1> [↑](#footnote-ref-18)
19. <http://www.namsdl.org/IssuesandEvents/NEW%20Involuntary%20Commitment%20for%20Individuals%20with%20a%20Substance%20Use%20Disorder%20or%20Alcoholism%20August%202016%2009092016.pdf> [↑](#footnote-ref-19)
20. Article 5 of the *European Convention on Human Rights* (the *Right to liberty and security)* states that:

    *Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:*

    *(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;* [↑](#footnote-ref-20)
21. Police and Community Safety could also be regular members of such a group, albeit less relevant for Elaine.

    [↑](#footnote-ref-21)