Doncaster Safeguarding Adults Board

Safeguarding Adult Review Report

In respect of Adult F

David Mellor, Independent Author

April 2021

1.0 Introduction

1.1 After not being seen for several days, Adult F was found deceased in the bungalow in which he lived in December 2019. He was 51 years old. He had sustained injuries consistent with an assault and four males were later charged with his murder. Three of these males were later convicted of his murder or manslaughter. Some of these males were also involved in a previously reported Hate Crime during which Adult F, who was gay, received abuse relating to his sexual orientation. During the months prior to his death, Adult F was in contact with a range of agencies as concerns escalated about his physical and mental health. Adult F was a heavy drinker with mobility problems arising from earlier strokes who had sustained serious injuries after repeatedly falling in the street.

1.2 Doncaster Safeguarding Adults Board decided to undertake a safeguarding adults review (SAR) on the grounds that Adult F died as a result of suspected abuse and there were concerns that partner agencies could have worked together more effectively to protect him. A description of the process by which this SAR was conducted is shown in Section 3 of this report.

1.3 David Mellor was appointed as lead reviewer for the SAR. He is a retired chief officer of police and has over eight years' experience of conducting statutory reviews. He has no connection to any agency in Doncaster.

1.4 An inquest will be held in due course.

1.5 Doncaster Safeguarding Adults Board wishes to express sincere condolences to the family and friends of Adult F.

2.0 Terms of Reference

2.1 The timeframe of the review is from 1st December 2018 to 31st December 2019.

2.2 The key areas of focus for the review are:

- Were internal policies and procedures followed at the relevant times by agencies involved in supporting Adult F?
- Were the South Yorkshire Safeguarding Adults Policies and Procedures followed and at the relevant times?
- Was Adult F's mental capacity assessed at the appropriate times? If yes was this recorded, decision specific and timely? What actions were taken as a response to assessments?
- Was fluctuating mental capacity considered as an issue and could this have had an impact on the way that services related to Adult F, especially in consideration to substance misuse?
- Were decisions and assessments accurately recorded and did decisions and actions accord with assessments?
- What arrangements and processes were followed when Adult F did not engage or attend appointments?
- Was information shared appropriately between agencies? In particular regarding Adult F as a vulnerable adult and a victim of abuse.
- Were appropriate services and support offered and available?
- What impact did Adult F's mental health, presenting behaviour and lifestyle choices have on proposed interventions and decision making?
- What support did services offer Adult F as a victim of abuse by local youths?
- Did the agencies respond in a timely and appropriate manner to concerns raised about Adult F?
- Did agencies work in an assertive and proactive way, giving consideration to legal options?
- Should contextual safeguarding be considered for Adult F?

3.0 Methodology

It was decided to adopt a systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Chronologies which described and analysed relevant contacts with Adult F were completed by the following agencies:

- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- Doncaster Council Adult Social Care
- NHS Doncaster Clinical Commissioning Group
- Rotherham Doncaster and South Humber NHS Foundation Trust
- South Yorkshire Police
- St Leger Homes
- Yorkshire Ambulance Service NHS Trust

The chronologies were analysed and issues were identified to explore with practitioners at a learning event facilitated by the lead reviewer and in subsequent conversations with practitioners from agencies which were unable to be represented at the learning event.

Adult F's mother and brother contributed to the SAR via telephone discussions with the lead reviewer. It is hoped that it will be possible to discuss the report with his mother and brother at the conclusion of the review.

The lead reviewer then developed a draft report which reflected the chronologies, the contributions of practitioners and the contributions of Adult F's family.

The report was further developed into a final version and presented to Doncaster Safeguarding Adults Board.

4.0 Glossary

Best Interests - if a person has been assessed as lacking mental capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.

Care Programme Approach (CPA) - is a framework to assess the care and support needs of people with mental health problems, develop a care plan and provide the necessary support. A care coordinator monitors the care and support provided.

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Mental Capacity Act (MCA): The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves and establishes a framework for making decisions on their behalf. This applies whether the decisions are life changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act.

The presumption in the MCA is that adults have the mental capacity to make informed choices about their own safety and how they live their lives. Issues of mental capacity and the ability to give informed consent are central to decisions and actions in adult safeguarding. All interventions need to take into account the ability of adults to make informed choices about the way they want to live and the risks they want to take. This includes their ability to understand the implications of their situation, to take action themselves to prevent abuse and to participate to the fullest extent possible in decision-making.

Problem Oriented Policing (POP) is an approach to tackling crime and disorder that involves the identification of a specific problem, thorough analysis to understand the problem, the development of a tailored response and an assessment of the effects of the response.

Section 42 Care Act 2014 Enquiry by local authority
This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),

- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Self-Neglect covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings, lack of self-care to an extent that it threatens personal health and safety, inability to avoid harm as a result of self-neglect, unwillingness to seek help or access services to meet health and social care needs and includes behaviour such as hoarding.

5.0 Synopsis

5.1 Adult F was described by his mother, who contributed to this review, as an extremely bright, funny, kind and well liked person who was a very good listener. She added that he was 'his own person'. She said that he realised he was gay at the age of thirteen. As a teenager he was a very promising actor - attending drama school, working with the National Youth Theatre and appearing on TV and in TV commercials. She said that during this period of his life he fell off a stage and hurt his back and was prescribed pain relief, implying that this was the beginning of a long term addiction to painkillers. He worked as a bus driver and in the hospitality industry but his use of illicit drugs and alcohol began to affect all aspects of his life, including his employability. Due to his intravenous drug use he became Hepatitis C positive and he had liver cirrhosis due to excessive alcohol consumption. He had also been treated for depression and anxiety. His mobility gradually deteriorated which was exacerbated following a stroke in 2017.

5.2 Doncaster Council's Short Term Enablement Programme (STEPS) – which provides support for up to six weeks when an adult is finding it difficult to complete daily tasks and when an adult is leaving hospital and needs additional support to regain skills and confidence – supported Adult F following a stroke. Doncaster Council's Wellbeing Team – which aims to ensure that all Doncaster residents have access to support, guidance and advice about problems and issues they may be experiencing, and to also maximise the individuals independence within the community regardless of any medical condition, physical disability, or mental health difficulty – then provided support to Adult F between January and April 2018. The Wellbeing Team registered him with community transport, linked him to a men's hobby group, worked with him to clean up his property which was becoming unkempt and supported him to attend a nearby lunch group.

5.3 In April 2018 Adult F moved to a bungalow in Denaby Main which had been offered to him by St Leger Homes - which is Doncaster Council's social housing company – on the grounds of his reduced mobility. He had previously resided in the Balby area of Doncaster. Adult F was also receiving support from Riverside – which provides a range of services including extra services to help sustain tenancies and care and support for people facing significant challenges in life. Additionally, Adult F had been receiving support for many years from Aspire Doncaster Drug and Alcohol Services (DDAS) which is a partnership organisation set up by Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and the registered charity the Alcohol & Drug Service (ADS). Adult F maintained a close relationship with his mother who lives in the USA. They remained in regular telephone contact and she would telephone local agencies on his behalf.

5.4 He had a fall at home and fractured his right ankle in July 2018. He received support from the district nurse service for a time and was offered support by Adult Social Care which he declined on the grounds that he felt that he did not need it.

5.5 On 6th December 2018 his Doncaster Drug and Alcohol Service (DDAS) key worker visited Adult F at home. He disclosed that he continued to drink a 70cl bottle of vodka each day, which he purchased from a local shop. He remained illicit drug free. He confirmed that social care was not involved with him. He had a forthcoming appointment with the DDAS doctor to plan an alcohol detox. However, his key worker reminded him that he had been admitted to hospital twice for alcohol detoxes over the past year and that as soon as his mobility allowed he had relapsed and begun drinking alcohol again. When asked what would be different this time, Adult F replied that he was unsure. The keyworker advised Adult F that a detox on its own was not enough to help him remain alcohol free. When asked what were the triggers for starting drinking again, he was unable to identify any. He was advised that repeated detoxes followed by relapses would have an adverse effect on his physical and mental health. Adult F was to see a DDAS nurse every two weeks so that he could work towards a further detox.

5.6 Later the same day Adult F was seen in clinic by the DDAS Doctor. Adult F said that the biggest factor in his continuing alcohol use was his poor sleep pattern. Non-prescribed treatments for Adult F's sleep problems such as adjustments to his behaviour and changing his expectations in respect of sleeping as he got older were discussed. The DDAS Doctor wrote to Adult F's GP to advise him of the current plan which was to continue with methadone to treat his opioid dependence, diazepam on a reduced dose and a one-off prescription of zopiclone to help him sleep. The DDAS Doctor added that Adult F may approach his GP for longer term medication to help him sleep and suggested that the GP consider a tricyclic antidepressant. (DDAS do not routinely prescribe antidepressants). At that time Adult F's GP was prescribing him amitriptyline – which treats pain, prevents migraine and treats depression and insomnia, spironolactone – a diuretic to prevent a build-up of fluid in the body and thiamine – which is often prescribed to alcoholics at risk of Vitamin B1 deficiency which is known to put the patient at risk of Wernicke-Korsakoff Syndrome – a chronic memory disorder. Adult F's next DDAS Doctor review was scheduled for 28th February 2019.

5.7 On 22nd December 2018 Adult F was taken to hospital after making a 999 call to report shortness of breath and pain in his legs.

5.8 On 31st December 2018 Adult F was again conveyed to hospital after a welfare visit by a Riverside worker. The welfare visit had been prompted by a telephone call from Adult F to Riverside on 29th December which reception staff had been unable to understand as Adult F appeared to be under the influence of alcohol at the time. Adult F told the Riverside worker who visited him that he had taken 'a box' of

amitriptyline, which Adult F was said to have purchased illicitly. (His GP had prescribed 56 amitriptyline tablets on 10th December 2018 – one to be taken at night although this could be increased to two). Two 10 inch knives were found down the side of Adult F's chair and four empty litre bottles of vodka were also seen.

5.9 The Riverside worker contacted the ambulance service who conveyed Adult F to hospital A&E where he was examined but not admitted. The hospital wrote to his GP to say that he had been taken to hospital following a mixed overdose of alcohol, amitriptyline, diazepam, co-codamol and methadone and had declined to be seen by the hospital mental health team and would access services in the community via his GP and his keyworker. He was documented to deny ongoing suicidal intent although noted to be tearful at times. He was also documented to 'have capacity' but it is not known if his capacity was formally assessed. Adult F's GP practice made several unsuccessful attempts to contact him by telephone on the date of his admission to hospital (31st December 2018) but there is no indication of any further follow up.

5.10 On 3rd January 2019 the DDAS keyworker visited Adult F who reported that he was keeping his alcohol intake to a minimum following the 31st December 2018 incident. When asked about the two knives, Adult F said he had planned to use them to take his own life. This was explored and he said he was no longer thinking about ending his life and was instead focusing of reducing his alcohol intake in advance of the detox he hoped would take place. He agreed not to put knives near his chair and would ensure they were kept in a safe place. Adult F was noted to continue to struggle with his mobility though he was managing to mobilise around the house well, completing daily living tasks without assistance including cooking, cleaning, making drinks and tending to his personal care. He presented as well kempt and was able to hold conversation appropriately throughout the visit.

5.11 Later in January 2019 the short-term loan of a wheelchair to Adult F was extended as he said he was due to have further surgery to 'remove metal pins' from his ankle.

5.12 On 28th January 2019, Adult F's GP continued the prescription of 56 amitriptyline tablets. There is no indication that any risks arising from Adult F's recent overdose of amitriptyline and other medication was considered when the prescription was continued.

5.13 On 9th February 2019 Adult F's DDAS keyworker completed a Functional Analysis of Care Environments (FACE) assessment in respect of Adult F. (FACE is an evidence-based tool to facilitate assessment with integrated risk management planning, which is undertaken on a regular basis or if there is a change in presentation). The assessment highlighted a number of issues including:

- Adult F had had a number of falls at home including a fall on 22nd July 2018 in which he fractured an ankle.
- He was considered to be of low risk of violence to others as there had been 'no recent attacks or assaults'.
- He was depressed and had suicidal thoughts, including jumping in front of traffic, although he said he would never do this because he was very close to his mother.
- As well as telephone contact with his mother, Adult F also had contact with one of her friends, who lived in Doncaster.
- He said he had taken overdoses of tablets to take his own life in the past but he said he had woken up after a few days 'feeling crap'. The 'amitriptyline overdose?' on 31st December 2018 was documented as was the risk that his alcohol use and depression could impact on his mental health.
- Adult F was considered to be neglecting himself. He was at risk of malnutrition as he restricted the amount he ate in order to prevent the food 'soaking up the alcohol', as he wished to feel the full effect of the latter. He was noted to have cirrhosis of the liver and was Hepatitis C positive. He was accessing treatment for the latter condition.
- He was considered to be at high risk of accidental self-harm, including alcohol relapse, overdosing and falls. In addition to his fractured ankle, he had had a stroke and suffered from right sided weakness of limb and mouth drop and his mobility remained compromised although he was able to mobilise around his home and for short journeys close to home.
- His risk of abuse or exploitation by others was considered to have fallen following his move to his current bungalow although he had been physically abused by a 'number of people' in his previous address during the summer of 2016.
- He had been illicit drug-free for two years.
- A risk of isolation was noted as his attendance at events at the local community centre had become sporadic recently.

5.14 The plan arrived at following the FACE assessment included discussing Adult F's case within the DDAS team and consideration of contact with his next of kin, his mother's friend or a neighbour, Riverside or the 'Adult Contact Team'.

5.15 On 18th February 2019 Adult F's DDAS key worker visited him accompanied by a Viral Hepatitis Specialist nurse who needed to take capillary blood samples to assess whether Hepatitis C treatment has successfully cleared the virus. Adult F reported that he was drinking up to 2 litres of vodka daily. It was not possible to discuss reducing his alcohol intake due to his level of intoxication. Adult F's mood fluctuated, at times laughing incongruently, and at times crying.

5.16 Also on 18th February 2019 Adult F contacted the police to report that his friend had taken £60 from him in order to purchase crack cocaine and had failed to return. He threatened to kill the friend and others. The police attended and found Adult F to be heavily intoxicated and took no further action.

5.17 On 19th February 2019 Adult F was arrested for carrying a knife in a public place after he had been refused service in a shop whilst affected by alcohol and opened his jacket to reveal a knife which he later placed in a bin.

5.18 Whilst in custody, he received a 'full vulnerability screen' from the liaison and diversion practitioner. He reported symptoms of withdrawal and a tremor was noted. When asked about thoughts of suicide, he became tearful and disclosed sexual abuse he had suffered as a child (the liaison and diversion practitioner later established that Adult F had previously been referred to DRASAC (Doncaster Rape and Sexual Abuse Counselling) but had declined their support. There was no evidence of acute mental illness and he was said to be orientated to time, place and person. It was documented that his needs were being met by DDAS.

5.19 He was subsequently transferred to hospital A&E following a seizure whilst in custody. He went on to have four more seizures in the ambulance, before having a seizure whilst undergoing the CT scan and then vomiting blood. The CT scan disclosed no fracture or haemorrhage. The police reported Adult F for summons.

5.20 DDAS contacted the hospital for an update on 25th February 2019 and were advised that Adult F had discharged himself on 23rd. No discharge information had been sent to DDAS, although a discharge letter had been sent to his GP. DDAS requested Adult F's discharge letter and medication information to be faxed to them as a prescription would require to be generated and taken to his pharmacy. However, DDAS were unable to contact Adult F at his home or by phone. It was not possible to complete a prescription for Methadone or Diazepam until he had contacted the service. The hospital was re-contacted and confirmed that take home medication was not given if someone chose to discharge themselves.

5.21 On 27th February 2019 DDAS reported Adult F missing to the police who found him safe and well in his home address later the same day. He attended an appointment with his DDAS keyworker the following day and explained that the police had taken his phone which was the reason why he had been out of contact with professionals. He said his brother, who lived in London, had visited him and given him a new phone, although he remained focussed on obtaining the return of his phone from the police for several days. (The police have confirmed that they did not take Adult F's phone). He reported drinking 1.5 litres of vodka per day. The dangers of continuing to do this were pointed out to Adult F. He said he had managed without Methadone but now needed it to be prescribed. He was advised that following recent events and serious concerns about his safety, his Methadone

would be dispensed on a daily supervised basis. Adult F was unhappy at the cost of daily travel to the pharmacy.

5.22 On 1st March 2019 the ambulance service attended Adult F's home after he contacted them via the 999 service. He reported that his heart was pounding and that his legs were 'going to explode'. On arrival he was found asleep in his living room. The ambulance crew assessment showed a possible cardiac issue which was not considered life threatening. No onward referral to Adult F's GP was made.

5.23 Also on 1st March 2019 Adult F reported the theft of his bank card during his recent hospital admission. He had subsequently discovered that over £1000 had been dishonestly withdrawn from his bank account. Adult F was later recorded to have recovered the money from the suspect - who was a neighbour - and did not support a prosecution. The police documented that they would make a safeguarding referral but did not do so.

5.24 On 3rd March 2019 Adult F signed a recovery plan which was intended to help Adult F reduce alcohol dependence and function on a daily basis. In the plan Adult F stated that he would like to work with his DDAS key worker to try and safely reduce his alcohol use.

5.25 On 6th March 2019 the ambulance service received a 999 call from a neighbour of Adult F who said he had found him lying on the floor of his bungalow in a drunken state and unable to get up. The neighbour reported that Adult F had been carried into his home by males she identified as 'drug users/dealers' and was concerned that they were 'robbing' Adult F. It later transpired that the people who carried him into his home had found him prone just outside his house. An ambulance was despatched but ultimately not required. The ambulance service notified the police but there were no officers available to attend. It was arranged that a Police Community Support Officer (PCSO) would visit Adult F the following day but it appears that the visit did not take place.

5.26 On 30th March 2019 Adult F called the ambulance service via 999 to report that he had collapsed on the floor, was unable to get up and had possibly lost consciousness at some point. On the arrival of the ambulance, Adult F had got up from the floor without assistance and declined transport to hospital. As Adult F said he was known to DDAS for alcohol use, no referrals were made.

5.27 After Adult F missed a number of DDAS appointments, it was decided on 7th May 2019 to withhold his methadone prescription. A fresh appointment was arranged for 21st May 2019.

5.28 On 11th May 2019 the police referred Adult F to the Adult Social Care Integrated Support and Assessment Team (ISAT) and Safeguarding Adults Hub (SAH) after he

smashed a neighbour's window, having drunk vodka to excess. The victim did not support a prosecution. St Leger Homes were also made aware of the smashed window.

5.29 On 13th May 2019 Adult F told his DDAS keyworker that he was 'desperate' for a detox and was advised to attend the appointment already arranged for 21st May 2019. He contacted DDAS again to request a detox on 17th May 2019.

5.30 On 17th May 2019 Adult Social Care decided that the three stage test for progressing the police referral to a safeguarding enquiry had not been met. The three stages are as follows:

- Has needs for care and support (whether or not the local authority is meeting any of those needs) and
- Is experiencing, or at risk of, abuse or neglect and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

5.31 Adult Social Care concluded that the third test was not met in that he was considered to be capable of keeping himself safe. He was noted to have had care and support needs in 2018 which had necessitated home care and therefore may still have care and support needs but it was considered that there was no evidence that he was unable to protect himself. He was also noted to be a perpetrator of anti-social behaviour (ASB).

5.32 Also on 17th May 2019 St Leger Homes Housing contacted the Wellbeing Team to check if Adult F was receiving any support and were advised that he had no social worker currently. St Leger Homes Housing then contacted the Adult Social Care (South) team to raise concerns that Adult F was possibly self-neglecting and were advised to make a referral to ISAT so that his capacity could be assessed 'to determine if there were any mental health issues affecting his behaviour'. St Leger Homes made the referral and also referred Adult F to DDAS. On 21st May 2019 St Leger Homes were informed that the safeguarding referral they made on 17th May 2019 had been closed. It is assumed that the St Leger Homes safeguarding referral was subsumed within the earlier police safeguarding referral.

5.33 Adult F attended the 21st May 2019 appointment with his DDAS keyworker, although he was over two hours late. He reported drinking 1.4 litres of vodka daily which he had been unable to reduce further. He continued to press for an alcohol detox and was advised that in order for this to be considered he would need to be seen more regularly. Adult F was unwilling to attend additional appointments due to his poor physical health since his stroke and because it had taken him three hours to get to this appointment. He said he would be happy to have more regular home

visits. This was to be discussed with the DDAS doctor. His weight was noted to have increased significantly. He said he was still waiting for his phone (and tablet) to be returned by the police, although the latter service had advised him that they did not have them. The plan was for Adult F to ensure his alcohol consumption did not increase, to take medication as prescribed and attend his next appointment.

5.34 On the same day St Leger Homes spoke to Adult F about the recent damage to his neighbour's window (Paragraph 5.28) and planned to send him a 'breach' letter.

5.35 In a discussion with Adult F's key worker on 23rd May 2019, the DDAS doctor noted that he relapsed quickly after previous detoxifications and was reluctant to engage in preparation work, had previously had a stroke which required prolonged hospital admission, had had a seizure that year which required ICU admission and then self-discharged. The plan was to review Adult F's physical health - in particular any deficits following his stroke. If physically stable, a detoxification was to be considered but it was to be made clear to Adult F this will not be repeated and he needed to try and form a relapse prevention plan although it is understood that this was overtaken by subsequent events, particularly his hospital admission on 12th July 2019.

5.36 On 30th May 2019 the RDASH Adult Mental Health Services Single Point of Access (SPA) received the safeguarding referral submitted by the police on 11th May 2019. The referral had been sent to the SPA by the Safeguarding Adults Hub. This prompted telephone contact between a mental health triage nurse and DDAS 'regarding safeguarding' which was not documented by either party.

5.37 On 7th June 2019 St Leger Homes received a call from one of Adult F's neighbours, complaining that for the past couple of days Adult F had had visitors and they had been sitting in the garden drinking and 'being loud'. Adult F was visited and said he did not realise they were being loud. St Leger Homes decided to monitor the matter.

5.38 On 9th June 2019 Adult F contacted the police after being verbally abused by a neighbour which he said he found upsetting. No further action was taken as Adult F did not support a prosecution.

5.39 On 11th June 2019 Adult F telephoned DDAS to request transportation to the prescribing review with the DDAS Doctor the following day. He said that the last time he attended a DDAS appointment it took him almost two hours travel each way and for the next few days his legs were very painful. He was advised that DDAS did not offer this facility. Adult F responded by saying that his appointment letter said he should contact the service if he had any special requirements. Advice was sought by the person who had responded to Adult F's call which resulted in him being advised that the service was unable to pay for a taxi for him and that if he was in receipt of

Personal Independence Payment (PIP) benefit, this included an element for mobility. Adult F said he has a bus pass which expired the following day before adding that he may be late for the appointment. (It is not known whether or not Adult F was in receipt of PIP).

5.40 On 12th June 2019 Adult F did not attend his appointment with the DDAS doctor as he was 'too poorly' (no further information documented). He was to continue with the same medication regime and the appointment was to be rearranged.

5.41 The following day (13th June 2019) Adult F phoned DDAS to say that his prescription was not at the chemist. He was informed that he would need to collect it from DDAS. When he attended to collect his prescription he was noted to be swaying and unsteady on his feet. Later the same day he tripped on a kerb and sustained a head injury including frontal facial damage for which he was hospitalised until 17th June 2019. It was documented that he had drunk three litres of vodka prior to the fall. On this occasion DDAS was notified of his admission by the hospital Drug and Alcohol Nurse Specialist (DANS).

5.42 A discharge letter was sent to his GP. There is no indication of any follow up by the GP practice although the practice sent Adult F a final warning letter on 18th June 2019 to advise that any further DNA's may result in removal from their register after he did not attend an appointment scheduled for 17th June 2019. He later contacted the GP to apologise.

5.43 On 27th June 2019 St Leger Homes received a telephone call from one of Adult F's neighbours to say that he had walked into her kitchen whilst drunk, mistaking it for his. ST Leger Homes contacted the police who confirmed that they were taking no further action in respect of this matter.

5.44 On 5th July 2019 DDAS received a phone call from Adult F's mother saying he had fallen at home and couldn't stand up or walk so was unable to collect his medication from the chemist. She asked if someone could deliver it or get a taxi to collect it for him. She was advised that this was not possible and if Adult F was unable to get up then he needed to phone for an ambulance to take him to hospital. She said she would pass on that advice to her son. Adult F did not contact the ambulance service or go to hospital in response to this advice.

5.45 On 8th July 2019 DDAS contacted Adult F's chemist to confirm he had missed 3 days medication. At that point all prescriptions were cancelled until it was established why Adult F had not collected them (DDAS had been informed that Adult F had fallen at home by his mother on 5th July 2019). DDAS contacted the hospital to check that he was not an inpatient – which he wasn't – and tried to phone Adult F but his phone was turned off. DDAS then contacted the police to request a safe and well check. The following day the police advised that they had spoken to Adult F.

5.46 On 10th July 2019 Adult F's key worker had a discussion with the DDAS Doctor and it was decided to issue Adult F with a '14 day contact letter'. Should Adult F respond, he would need to attend an appointment to discuss his treatment and say how he would maintain engagement. The letter was sent the following day offering an appointment for 26th July 2019.

5.47 On 11th July 2019 the DDAS key worker followed up the letter with a phone call to Adult F and advised him that he had now been off treatment for six days and if he wished to be re-started he would need to see a prescriber. Adult F appeared confused saying he had been in hospital to which his key worker responded by saying that this was not the case as DDAS had contacted the hospital on 8th July 2019. An appointment was booked for 11am the following day and it was explained that if he was late, his treatment would not be re-started.

5.48 On 12th July 2019 Adult F arrived early for the appointment with DDAS. He was noted to be walking with a stick, unsteady on his feet and complaining of pain to his left knee which appeared swollen. A urine screen was positive for Methadone and Benzodiazepine only. He presented as confused and unable to account for the events of the past seven days. He could not recall travelling to DDAS that morning. Absence of withdrawal symptoms was a concern as he was dependant on alcohol and usually consumed a bottle and a half of Vodka per day and was taking 40mgs Methadone. He was unclear why he was attending, didn't appear to be aware that he had not collected Methadone, Diazepam or his medication blister pack. He was asked what help he needed from DDAS and was focussed on having collections at the pharmacy reduced. He was very grey in pallor and a yellow tinge to his eyes was noted. It was decided that a prescription for Methadone or Diazepam would not be written because of concerns about his current presentation and he was advised to attend hospital to which he reluctantly agreed. His key worker was concerned that he may have suffered a head injury, a further stroke or possible Wernicke's Encephalopathy, a condition which affects the brain and, as previously stated, caused by a lack of vitamin B1 (thiamine). An ambulance was called and Adult F was conveyed to hospital. Information was given to the ambulance crew including his care plan, and risk assessment for up to date relevant information relating to physical and mental health along with substance use. Adult F was admitted to hospital for sudden alcohol withdrawal. He was to receive detoxification therapy. He was also diagnosed with a duodenal ulcer.

5.49 On 19th July 2019 Adult F's key worker contacted the hospital to check on his condition and was advised that Adult F was fluctuating between being medically fit for discharge and not. He was suffering from significant memory impairment. He had been re-started on 40mls of Methadone which the hospital planned to reduce during admission and also re-started on 4mg of Diazepam – which would be halved that day and stopped after the forthcoming weekend. The reason for reduction was to

reduce the strain of sedative medication on Adult F's cognition. General atrophy had been seen on a brain scan completed in February 2019 and a further scan was to be completed. Adult F's memory impairment was thought to be alcohol related brain damage. The Integrated Discharge Team (IDT) was to be involved once Adult F was medically fit for discharge due to 'capacity issues'.

5.50 On 24th July 2019 the Hospital updated Adult F's key worker that Methadone had been reduced and Diazepam tapered off without withdrawal symptoms, although he remained confused.

5.51 On 26th July 2019 Adult F's DDAS key worker visited him in hospital. Adult F was said to continue to struggle with his memory and was unable to clearly recollect his actions over the past three weeks. Nor was he able to retain new information clearly. He was no longer prescribed Methadone or Diazepam and no overt signs of withdrawal had been noted. The plan was to have assessments completed by the IDT, occupational therapy and the memory team in order to create a package of care. The hospital DANS would keep DDAS informed of decisions made in respect of Adult F.

5.52 On 28th July 2019 Adult F was seen by the ward doctor and noted to present as coherent. There were no concerns about his capacity. He was discharged from hospital on 1st August 2019. It is understood that following the IDT assessments in hospital he declined support.

5.53 On 12th August 2019 Adult F phoned DDAS to say he was at home having been discharged from hospital. He asked to speak to his key worker and was advised that she was on leave that week. He also asked to speak to the doctor and was told that was not possible. He said his legs were painful which prevented him collecting medication from the pharmacy. He became argumentative and ended the call. The DDAS nurse who had taken Adult F's call then checked his notes and established that there was no hospital discharge summary on their system. DDAS contacted the hospital DANS who advised that Adult F was discharged on 1st August 2019 and that 'his medication had been stopped' during the admission. The discharge information was uploaded into the DDAS system and Adult F's key worker was to be advised of the situation.

5.54 On 13th August 2019 Adult F was found guilty of the February 2019 offence of possession of a bladed weapon (Paragraph 5.16) and received 11 weeks imprisonment, suspended for 12 months and costs of £200.

5.55 On 14th August 2019 a DDAS nurse returned a phone call from Adult F who asked if his medication, specifically Methadone and Diazepam could be delivered to him since he was unable to leave his property following his recent hospital admission. The nurse made several unsuccessful attempts to explain to Adult F that

he was no longer prescribed any treatment from DDAS. The nurse ended the call as Adult F's language was becoming 'repetitive and unhelpful'. His key worker was to be updated.

5.56 On 25th August 2019 the police attended Adult F's address on two occasions. The first incident involved a call from Adult F during which he threatened to begin shooting children. Prior to attending, the police conducted a risk assessment as there had been mention of a firearm. However, no firearm was subsequently found and Adult F was noted to be 'heavily in drink'. The second incident arose when Adult F phoned the police to report that a neighbour was shouting names at him. Adult F, who was noted to be a 'repeat caller' to the police who had ongoing issues with his neighbours, was documented to have 'no carers or anyone to help him'. No further action was taken.

5.57 On 27th August 2019 Adult F called the police and the fire and rescue service to report that a bungalow on his street was on fire. The police attended and established that there was no fire. Adult F was noted to be intoxicated. A vulnerable person marker was added to the police call recording system in respect of Adult F.

5.58 On 29th August 2019 Adult F was initially taken to hospital locally with a head injury and alcohol withdrawal related seizures but was transferred to the Royal Hallamshire Hospital Neurology after a CT scan disclosed a massive subdural haematoma. There he was treated conservatively with no surgical intervention required. He experienced further seizures – thought to be alcohol withdrawal related - during his admission to the Royal Hallamshire and was treated with anti-epileptic medication. He was also treated with Chlordiazepoxide (alcohol detox medication) but was noted to be non-compliant with this medication.

5.59 On 5th September 2019 Adult F did not attend an appointment with DDAS. It was noted that he was not currently prescribed medication by DDAS and it was agreed that there would be no further review until he re-engaged.

5.60 Adult F was repatriated to the local hospital on 7th September 2019 with a request for a further CT scan to be taken to monitor progress of the subdural haematoma. On the same date he was referred to the Magnolia Lodge Neurorehabilitation Inpatient Unit by the Royal Hallamshire Hospital as he now required rehabilitation. (The Magnolia Neurorehabilitation Inpatient Unit works with people coping with a range of cognitive, physical and/or emotional symptoms following a severe brain injury, as well as other neurological conditions).

5.61 On 11th September 2019 an MDT meeting at Magnolia Lodge discussed the referral. Adult F was noted to have a long term alcohol dependency who lived 'with support' in a bungalow. (Adult F was not receiving any support package at that time) He was well known to addiction services. He was said not to have engaged with

therapy at the Royal Hallamshire Hospital and was difficult to rouse. The plan was to await a reduction in chlordiazepoxide and review him again. It was documented that he would need to be engaging with therapy and have active rehabilitation goals if Magnolia Lodge was to accept him.

5.62 On 13th September 2019 DDAS discharged Adult F from the service as he had not attended his last appointment and had not made any contact with the service. He was last on prescribed treatment in July 2019 which was discontinued in hospital under monitoring. Adult F was to be provided with all relevant contact details for him to re-access services if he wished. Discharge letters were sent to Adult F and his GP practice. DDAS remained unaware that Adult F had been hospitalised since 29th August 2019 despite the fact that this was documented within RDASH electronic records which, unfortunately does not allow information to be shared between different RDASH functions, in this case DDAS and Magnolia Lodge Neurorehabilitation Unit.

5.63 On the same date one of Adult F's neighbours rang St Leger Homes to express concern that Adult F may be in hospital or have passed away. St Leger Homes checked with the 'adult contact team' and there was no information 'on the system' to suggest Adult F was in hospital or had died.

5.64 On 16th September 2019 Adult F was reviewed at hospital by a clinical nurse specialist and a neurology consultant. A discussion with a neuro physiotherapist identified that Adult F was then back to his pre-injury level of function and mobility and therefore there were no clinical indicators to support a neurorehabilitation placement. It was noted that he would need support with managing his alcohol intake as his alcohol use was now a greater risk in light of his brain injury. He was to be supported to engage with the Headway support group as part of his discharge care plan, although there was no reference to this in the discharge letter sent to his GP (see next paragraph). Adult F was discharged from Neurology and discharged from hospital two days later (18th September 2019).

5.65 The hospital sent a discharge letter to Adult F's GP practice. The letter was brief, stating that he had suffered an acute left-sided subdural haematoma and that his past medical history included a previous left frontal haematoma. The discharge letter requested the GP to change Adult F's medication. In addition to the previously prescribed amitriptyline, spironolactone and thiamine, he was from that point also prescribed lactulose, lansoprazole (to reduce stomach acid), levetiracetam, morphine sulphate, paracetamol (pain relief), senna (to relieve symptoms of constipation), Vitamin B compound strong tablets and amlodipine. Having been unable to contact Adult F by phone, the GP practice wrote to advise him of the changes. The GP practice also received letters from Hospital Trauma and Orthopaedics and from Hospital Rehabilitation.

5.66 On 11th October 2019 the ambulance service received a 999 call from Adult F but it was unclear which emergency service he required. He said he had had a stroke but was documented to be incoherent at times. On the arrival of the ambulance, Adult F said that he was expecting the police. No clinical need for the ambulance was identified. Adult F did not consent to any referrals to social care or alcohol services. His home was noted to be 'unkempt'.

5.67 On 14th October 2019 St Leger Homes received a telephone call from one of Adult F's neighbours, to say that he had been shouting abuse at her and so she had contacted the police. St Leger Homes contacted the police who advised that they had attended and had called an ambulance as they were concerned about Adult F's mental health and poor physical health due to alcohol use. The ambulance service made telephone contact with Adult F who declined their assistance. St Leger Homes were to send a warning letter was to be sent to Adult F.

5.68 The following day the police were called after Adult F was alleged to have damaged a neighbour's vehicle. Adult F was reported for summons. St Leger Homes were also aware of the incident.

5.69 On 16th October 2019 the police arrested Adult F after a neighbour complained that he had shouted and swore at her and her daughter. He was kept in custody overnight to attend court the following morning. St Leger Homes and the police discussed concerns regarding Adult F's risk to himself and others in the area and about the condition of his property. A further safeguarding referral was to be made. Whilst in custody, both panes of Adult F's front bay window were smashed. No suspect was identified.

5.70 The following day (17th October 2019) the Wellbeing Team received a referral from St Leger Homes asking if there was any support they could provide as Adult F was drinking alcohol heavily, he was perceived to be a 'nuisance' and a perpetrator of ASB, could be aggressive and his property 'was in a state'. The referral was also sent to safeguarding.

5.71 On 21st October 2019 the Wellbeing Team decided that it was not appropriate for the concerns relating to Adult F to be addressed by them, given the number of agencies they perceived to be involved with Adult F. They also noted that the referral had been sent to Safeguarding. ISAT acknowledged the safeguarding referral which related to criminal damage and 'possible mental health paranoia' and suicidal thoughts but only when in drink. The referral stated Adult F to have mental capacity. ISAT appear to have decided that as the presenting issues were largely a police matter and that St Leger Homes were also involved with Adult F, no further action was necessary. On the same date St Leger Homes arranged to make a joint visit to Adult F with the police to serve the tenancy breach letter on him.

5.72 On 23rd October 2019 Adult F was conveyed to hospital by the ambulance service after taking an overdose of medication (19 amitriptyline tablets) whilst intoxicated. The ambulance service had attended and found Adult F on the floor and unable to get up. He was abusive to the crew and refused to go to hospital but the crew decided to transport him as they considered his level of intoxication to be impacting on his capacity to retain and weigh up information. Adult F continued to present as aggressive and uncooperative at hospital, declined treatment or assessment and discharged himself against medical advice. There is no indication that Adult F's capacity to make the decision to discharge himself was considered by the hospital. No safeguarding referral appeared to be considered by either the ambulance service or the hospital.

5.73 On 25th October 2019 Adult F assaulted a police officer who attempted to remove medication from him, fearing that he intended to take an overdose. Adult F was arrested. The ambulance service was also present and they then transferred Adult F hospital which documented that he had taken a 'staggered overdose' during the day. Adult F declined 'crisis team' input and was assessed as having the capacity to do so. Adult F's GP and DDAS were advised of the incident but no referral for support appears to have been considered at that time.

5.74 Later the same day the ambulance service received a further 999 call from Adult F to say that he had left his medication on a wall outside the hospital following his discharge. He was concerned that someone had picked this up leaving him with no medication. He said he had no credit on his mobile phone to contact the hospital or his GP. He asked if the police or ambulance service could collect the tablets for him. He was advised to contact NHS 111 to obtain a replacement prescription.

5.75 On 26th October 2019 Adult F contacted the ambulance service via the 999 system to report that he was unable to breathe, although he was noted to be speaking in full sentences, was clammy and having cold sweats. An ambulance was despatched which found Adult F to be agitated and drinking vodka. No clear clinical concerns were established and Adult F was documented not to wish to go to hospital.

5.76 On 31st October 2019 Adult F made numerous calls to the police - sounding confused on occasions and 'making no sense' on others. The police attended after a call in which Adult F said that people with 'blades' were trying to get into his home. The police found no-one other than Adult F present and it was documented that the officers would submit a safeguarding referral but there is no indication that this was done. Later the same day the police attended Adult F's address after he reported children walking past his house had shouted 'nonce' and 'idiot' – words he thought had been directed at him and said that it was an 'ongoing issue'. The police found no young people present and noted Adult F to be a frequent caller and a 'major cause of anti-social behaviour on his street'.

5.77 On 2nd November 2019 the police responded to a request for assistance from the ambulance service who were with Adult F who was said to be 'in drink' and making threats to kill his neighbours 'for being racist towards him'. When the police attended Adult F was found to be calm and saying that he did not want to hurt anyone but wanted his medication. He was advised to contact the hospital in the morning. During his initial 999 call to the ambulance service Adult F reported feeling suicidal and said he was housebound with no carers. The ambulance service call handler attempted to discuss his care needs with Adult F who was documented to say that he didn't need and couldn't afford carers.

5.78 On 5th November 2019 the ambulance service requested police assistance as Adult F was in drink and threatening to kill someone. The police attended and arrested Adult F for failing to appear at court on 31st October 2019 in respect of the damage to his neighbour's car (Paragraph 5.68). The ambulance service phoned Adult F's GP practice to express concern that Adult F had called the ambulance service seven times since 11th October 2019, been transported to hospital twice, was showing symptoms of confusion and appeared to have lost his medication. (The last record of medication prescribed by his GP practice was on 23rd October 2019 although the Out of Hours GP service issued Adult F with a full month's prescription on 9th November 2019). The ambulance service asked for information about any agencies providing support to Adult F. This contact with Adult F's GP practice does not appear in the ambulance service chronology. The GP practice responded to the ambulance service contact by discussing Adult F at an MDT meeting and has advised this review that 'as he was attending the other services and home assistance' they decided to 'observe him and see where we go for here as he was still registered'.

5.79 On 19th November 2019 the police advised St Leger Homes that Adult F's case had been passed to the police Vulnerability hub who were to work with him to try and change his behaviour. Adult F was also due in court shortly. St Leger Homes planned to serve a 'breach' letter and inspect the condition of Adult F's property.

5.80 On 30th November 2019 Adult F phoned the police to report that he had been verbally abused by three local youths who had called him a 'fucking faggot' and thrown a bottle at him. He said he knew the names of two of them. The police recorded a Hate Crime based on Adult F's sexual orientation and the matter was closed pending any further evidence coming to light. A crime of common assault was subsequently recorded in respect of the bottle thrown at Adult F and this remained under investigation at the time of Adult F's death.

5.81 On Monday 2nd December 2019 the Maritime and Coastguard Agency (MCA) contacted the police to advise that Adult F had rung them to say that he was drowning and needed assistance. It transpired that he was actually lying on his bed

within his home address. The police documented that Adult F was potentially vulnerable due to mental health issues but decided that attendance was unnecessary. However, the police later attended Adult F's home address after he reported a disturbance there. The police found no evidence of a disturbance other than a further broken window which Adult F, who appeared heavily intoxicated, was unable to explain. The police notified St Leger Homes of the damage and made an adult safeguarding referral. St Leger Homes visited Adult F on the same date but were unable to get an answer and so they posted the 'breach' letter through his letterbox.

5.82 On 4th December 2019 a the Safeguarding Hub considered a further safeguarding referral from the police regarding the 2nd December 2019 incident at Adult F's home which stated that he was heavily intoxicated and 'not making much sense'. There was also a reference to the broken window and the arrangements which had been made to have it repaired. It was decided that the three stage test had not been met, specifically that there was no evidence that Adult F was unable to protect himself from harm. The safeguarding referral raised concerns about Adult F's mental health and so the referral was forwarded to the adult mental health services SPA, where a mental health triage nurse decided that there was no current role for secondary mental health services as Adult F did not have a diagnosed acute mental health problem.

5.83 Also on 4th December 2019 the police initiated a Problem Oriented Policing (POP) Plan in respect of Adult F as he had been identified as causing high demand on the police. He had made a total of 41 calls to the police in the preceding eleven month period. An officer was allocated to manage the plan by visiting Adult F weekly and working with agencies to reduce demand on agencies such as the police and St Leger Homes from Adult F, whilst also improving his engagement with services. Further objectives of the plan included tackling crime and anti-social behaviour and protecting the vulnerable who were defined as Adult F, his neighbours and the community.

5.84 On 14th December 2019 concerns were raised as Adult F had not been seen for a number of days. The police attended his address and found the windows boarded up. Checks were made with family, hospitals and neighbours. The following day the fire service forced entry to Adult F's address where he was found deceased with signs of violence to his body. He appeared to have been deceased for some time.

6.0 Views of Adult F's family

6.1 Adult F's mother lives in the USA. She contributed to the review by telephone. She had lived and worked in Doncaster for many years before moving to the USA.

6.2 She said that Adult F was an extremely bright, funny, kind and well liked person who was a very good listener. She added that he was 'always different', and realised he was gay at the age of thirteen. She said that her son 'was his own person'.

6.3 As a teenager he was a very promising actor attending drama school, working with the National Youth Theatre and appearing on TV and in TV commercials. She said that during this period of his life he fell off a stage and hurt his back and was prescribed pain relief. She implied that this was the beginning of a long term addiction to painkillers.

6.4 She said he became a bus driver which was a role she said he loved, getting on very well with the children he transported. However, he had begun using illicit drugs and tested positive for drugs and lost his job as a bus driver. His mother felt that he never settled after this setback.

6.5 He had been living and working in London for some time before returning to Doncaster where he had been brought up. His mother said that by this time he had a drink problem. She said that in Doncaster he volunteered at the hospital and taught English to migrant children who lived in his community.

6.6 When she married a US citizen, she moved to live in the USA permanently. At the time she left the UK she felt that her son was fairly settled in a nice apartment in Doncaster. Initially she would visit Adult F in the UK once or twice a year but she became ill and was unable to travel to the UK. She said that one of her granddaughters, who did not live far away from Adult F, assumed greater responsibility for looking out for him and helped him deep clean and decorate one of the homes he lived in.

6.7 Adult F's mother said that his life became 'very dangerous' whilst he was living in Balby, where she felt that he made friends with some 'really awful' and 'very dangerous' people and was 'beaten up' several times. This precipitated his move to the bungalow in Denaby where he was living at the time of his death. She said that she arranged for him to have all the things he needed such as a fridge but added that if she sent her son money she was worried he would spend it on alcohol so she sent him groceries every fortnight.

6.8 Although she was no longer well enough to visit Adult F, she said she tried to 'keep on top of things' and would phone him every day or he would ring her. When

her son needed an early morning call to remind him to go to an appointment, she would stay up late in the USA to make the call to her son at the appropriate UK time.

6.9 She said that Adult F had ‘a lot of trouble’ from some of his neighbours particularly a woman she said ‘persecuted him, stole money from him and incited other neighbours’. She added that one neighbour’s grandson stole his ipad, used his debit card and withdrew ‘quite a lot’ of money from his bank account (See paragraph 5.23).

6.10 Adult F’s mother went on to say that there was a ‘group of lad’s who appeared to hold the view that they ‘didn’t want any gays in the village’ and began to persecute him. She said that there were four of these young people and one of them apologised to Adult F for his behaviour but the others did not. She said that the police became aware of the situation but she felt that the police had labelled Adult F as a drunk.

6.11 Looking back, Adult F’s mother felt that her son became very ill during the last three years of his life. She said he had become very lonely and she questioned whether he was of ‘sound mind’ to make decisions about his care. She added that her son could ‘shut down’ and not want to talk to anyone. She said that when he was taking illicit drugs he could be very manipulative and she was sure that he was capable of aggression at times.

6.12 However, she felt that there was ‘no communication’ between the agencies involved with her son - citing an occasion when Adult F was admitted to hospital and DDAS was unaware - and that much of the support he received was ‘short term’. She also felt that there was sometimes a lack of continuity in the professionals working with him.

6.13 She felt that insufficient account was taken of her son’s mobility issues. She said that he needed to take a bus to the pharmacy and that it was a long walk to DDAS from where the bus dropped him off. She said that the act of getting on and off the bus was a ‘trial’ for her son.

6.14 She felt that agencies didn’t always demonstrate that they cared about her son and may have seen her calls on his behalf as a nuisance.

6.15 When Adult F was about to be discharged from hospital on one occasion, his mother said she rang the hospital from the USA and asked them not to discharge him as ‘he would get a bottle of vodka and he would die’. She said that she asked the hospital to ‘section’ him (under the Mental Health Act) but instead they ‘sent him home in his bedroom slippers’.

6.16 Adult F's mother was very grateful for the support provided by a professional from the Wellbeing Team, who she said had 'really tried' and put a calendar on her son's wall and wrote in his appointments.

6.17 Adult F's mother said that she hoped that this review would prevent other people 'falling through the cracks'.

6.18 Adult F's brother has also contributed to this review and said that his brother was a very promising actor during his teenage years but 'developed a liking for drugs' around that time and was 'surrounded by people of a similar ilk'. He said Adult F was from a 'middle class background' and had inherited money, but his issues with alcohol and drugs seriously affected his life.

6.19 His brother said that Adult F had been employed in bar work and what his brother described as 'unskilled work'. His brother said Adult F was unable to 'extricate himself' from his involvement with drugs and alcohol and that this ultimately 'destroyed his health'. He felt that his brother mostly rejected support but that agencies in contact with him had put him in the 'too difficult pile'.

6.20 Adult F's brother was critical of the decision to offer him the bungalow in Denaby. He felt that he attracted adverse attention through being an 'outsider' who was gay, 'a character' and having an income which exposed him to the risk of violence and/or exploitation.

6.21 At the time the POP plan was initiated shortly before his death, Adult F was said to be in an on/off relationship with a male, the only known details of whom were his first name and the area of Doncaster in which he lived. It has therefore not been possible to involve this person in the review.

7.0 Analysis

7.1 In this section of the report the learning themes which have emerged from this review will be addressed. Addressing the learning themes will also allow the terms of reference questions set out in Section 2 of this report to be addressed.

Care and treatment of Adult F's harmful alcohol use
Terms of Reference question:
Were decisions and assessments accurately recorded and did decisions and actions accord with assessments?

7.2 Adult F was a complex client for DDAS to support. His reported consumption of vodka varied between 1.5 and 2 litres a day for much of the period covered by this review.

7.3 In March 2019 he signed a recovery plan which was intended to help him reduce his alcohol dependence and function better on a daily basis (Paragraph 5.24) but there is no indication that the recovery plan was adhered to. He continued to press for a detox but this was considered to be potentially harmful to his physical and mental health and there was no indication that he was motivated to avoid relapse. Adult F had had two previous alcohol detoxes and DDAS was reluctant to sanction a further alcohol detox without some indication that he would work with them to avoid relapsing. However a further detox was to be considered if Adult F was physically stable (Paragraph 5.35) but it was made clear to him that no further detoxes would be entertained thereafter.

7.4 However, this emerging plan was overtaken by events when Adult F's concerning presentation necessitated hospital admission on 12th July 2019, during which he received detoxification therapy (Paragraph 5.48). During this admission Adult F's methadone and diazepam were gradually reduced and then stopped and no overt signs of withdrawal were noted. DDAS has advised this review that hospital detoxes tend to be 'unstructured' in that they are invariably driven by another health need and in order to treat that other health need, the hospital will manage the assisted withdrawal or stabilisation of the patient. In this case Adult F was also treated for a duodenal ulcer. Additionally, hospital detoxes may not have been preceded by a motivation to change and may not be followed by effective support post detox to address previous behaviours and thinking and achieve lasting change. NHS guidance emphasises that whilst it is an important first step, withdrawing from alcohol is not an effective treatment by itself and further treatment and support is required in the longer term (1).

7.5 After Adult F's discharge following the hospital detox there was an opportunity for DDAS to play a role in post detox support but this did not happen. DDAS were not notified of Adult F's discharge despite maintaining regular contact with the hospital

during Adult F's admission. Thereafter Adult F's priority appeared to be to obtain further prescriptions of methadone and diazepam from DDAS, but DDAS was no longer prepared to prescribe them on the basis that these drugs had been stopped during his hospital detox (Paragraph 5.53 and 5.55). Adult F was discharged by DDAS on 13th September 2019 as he had not attended his last appointment and not made further contact with the service. The reason Adult F had not been in contact with DDAS was that he had been hospitalised from 29th August until 18th September 2019 for treatment to a subdural haematoma. Discharging Adult F without making efforts to locate him and check on his welfare was unsatisfactory and carried risks. DDAS has advised this review that they followed their Engagement and Discharge of Patients Policy, which includes holding an MDT meeting and reviewing risk assessments prior to discharge. However, one might have expected Magnolia Lodge to make contact with DDAS when they were considering his suitability for neurorehabilitation given that they were aware that he was 'well known' to addiction services (Paragraph 5.61).

7.6 Looking back at events, this discharge from DDAS appeared to be a turning point in the care and support provided to Adult F and, given his tenuous link to primary care, left him isolated from care and support.

Hospital discharges

7.7 Notification to DDAS of Adult F's discharges from hospital was inconsistent and appeared to largely depend on the involvement of the hospital's Drug and Alcohol Nurse Specialist (DANS). (This review has been advised that there was a lack of continuity in DANS cover at that time). The lack of notifications adversely affected continuity of care for Adult F. DDAS was not notified of Adult F's discharge on 23rd February 2019 (Paragraph 5.20) which delayed the resumption of Adult F's prescription of methadone and diazepam. DDAS did not find out about Adult F's 1st August 2019 discharge from hospital until he contacted them twelve days later (Paragraph 5.52) despite close liaison between DDAS and the hospital during this admission for detox therapy and an agreement that the DANS would keep DDAS informed of decisions made in respect of Adult F (Paragraph 5.51). The lack of involvement of DDAS in discharge planning for a patient who had undergone a hospital detox rendered this discharge unsafe.

7.8 DDAS was not notified of Adult F's admission to the Royal Hallamshire Hospital on 29th August 2019 and was not advised of his repatriation to hospital locally or contacted by Magnolia Lodge when they were considering Adult F's suitability for rehabilitation. Nor were DDAS notified of Adult F's eventual discharge from hospital on 18th September 2019. Although DDAS had recently discharged Adult F from their service, given his significant history it would be important for the hospital to seek to involve DDAS in Adult F's discharge planning as the hospital had noted that he

would need future support with managing his alcohol intake as his alcohol use was now a greater risk in light of his brain injury (Paragraph 5.64).

7.9 It is unclear which agency or agencies would be responsible for ensuring the implementation of the discharge care plan drawn up to support Adult F following his discharge from hospital on 18th September 2019 after recovering from the subdural haematoma. As stated above DDAS were not aware of this admission and were not involved in discharge planning. Discharge letters were sent to Adult F's GP in respect of medication and from Hospital Trauma and Orthopaedics and Hospital Rehabilitation but these did not prompt any follow up action from the GP practice, other than implementing the medication changes. It is understood that Adult F had declined to engage with occupational therapy and physio therapy assessments. It was stated that Adult F was to be supported to engage with the Headway support group but again it is unclear how this was supposed to happen and who was responsible. It is difficult to avoid the conclusion that this was a further unsafe hospital discharge.

7.10 Adult F discharged himself from hospital on 23rd October 2019 against medical advice (Paragraph 5.72) and, as stated elsewhere in this report, there appeared to be no consideration of whether this intoxicated person with compromised memory function had the capacity to decide to self-discharge.

7.11 It is worthy of note that St Leger Homes were unable to establish whether Adult F was in hospital or not when concern was raised by Adult F's neighbours on 13th September 2019 that he had not been seen for some time (Paragraph 5.63). Adult F had been in hospital since 29th August and remained so until 18th September 2019. St Leger Homes was advised by the 'adult contact team' that there was no information 'on the system' that Adult F was in hospital which suggests that information systems may not be completely reliable.

Lack of follow up by Adult F's GP practice

Terms of Reference question:

Were appropriate services and support offered and available?

Did the agencies respond in a timely and appropriate manner to concerns raised about Adult F?

7.12 Adult F rarely visited his GP practice. The practice is situated 13 miles from his bungalow in Denaby. Adult F's mobility issues would have made travelling to see his GP quite challenging. He would have needed to catch two buses and three short walks would also have been necessary. It is not known why Adult F was not advised or encouraged to register with his local GP practice in Denaby which is close to the pharmacy from which he obtained his medication.

7.13 Generally, Adult F's GP practice made only limited attempts to follow up on his many hospital attendances and admissions. For example when he was admitted to hospital following the 31st December 2018 overdose, his GP practice made several unsuccessful attempts to contact him by telephone on the date of his admission, but there is no indication of any further follow up (Paragraph 5.9). There is no indication of any follow up after his discharge from hospital on 17th June 2019 after he had fallen and sustained a head injury (Paragraph 5.42), nor was there any GP follow up to his discharge from hospital on 1st August 2019 after his detoxification therapy (Paragraph 5.52) and the only action the GP practice appears to have taken following his discharge from hospital on 18th September 2019, after his treatment for a subdural hematoma, was to write to him to advise him of changes to his medication.

7.14 When the GP practice was contacted by the ambulance service on 5th November 2019 to express concerns about Adult F, his case was discussed at an MDT at which it was decided to 'observe' him and 'see where we go' on the grounds that he was 'attending the other services and home assistance' (Paragraph 5.78). It is unclear which services the GP practice believed Adult F to be attending because by 5th November 2019 he appeared to be in receipt of no support from services. Given that the GP practice held a substantial amount of information about Adult F, including the fact that he had been discharged from DDAS after many years of support, one might have anticipated a more proactive response to the ambulance service concerns and possibly the consideration of a safeguarding referral.

7.15 The increasingly frequent ambulance service call outs to Adult F would have been automatically notified to his GP practice but these did not prompt follow up action.

7.16 As stated elsewhere in the report, there is no indication that the GP practice conducted a risk assessment or considered whether it was safe to continue the current prescribing method after Adult F's overdose on 31st December 2019 (Paragraph 5.12).

7.17 The GP practice sent Adult F a final warning letter on 18th June 2019 to advise that any further Did Not Attends (DNA) may result in removal from their register after he did not attend an appointment scheduled for 17th June 2019 (a date on which he was being discharged from hospital (Para 5.42). Clearly DNAs are an important issue. More than 15 million GP practice appointments are wasted each year because patients do not turn up and fail to warn surgeries that they will not be attending. The cost of these missed appointments has been estimated to be in excess of £216 million (2). An alternative way of looking at DNA appointments is to consider whether they might be 'Does Need Appointments', in that the DNA may indicate that the patient may not have been able to attend for reasons beyond their control such as a hospital admission or because of mobility issues as in this case. It may have been

useful to explore why Adult F was not attending GP appointments, which might have led to a transfer to a more geographically convenient practice and possible reduced his reliance on the 999 system to ring the ambulance and police services.

Adult F's compromised mobility and risk of falls

7.18 The FACE assessment carried out by Adult F's keyworker in February 2019 found that his mobility remained compromised although he was able to mobilise around his home and for short journeys close to home. (Paragraph 5.13). The same assessment found him to be at high risk of accidental self-harm including the risk of falls. Contributory factors were documented to be the stroke he suffered in 2017 and the right ankle he fractured during a fall at home in July 2018.

7.19 His compromised mobility and high risk of falls made it challenging for him to attend appointments and comply with daily visits to the pharmacy required during the period when supervised administration of methadone was insisted upon for safety reasons. The pharmacy was 0.4 miles from his bungalow. Even this short distance would have been difficult for Adult F to manage as his mother's contribution to the review indicates (Paragraph 6.13). The DDAS premises are 6.9 miles from his bungalow and necessitate catching two buses and walking for 49 minutes for someone without any mobility issues, although this review has been advised that he could have attended the DDAS hub at Mexborough (1.7 miles away and one bus and 10 minutes walking) for most appointments but was said to prefer the main DDAS premises as he knew the Doctor and staff. As stated elsewhere in this report, his GP practice is situated 13 miles from his home. Adult F appears to have had a bus pass and had been registered with community transport although the extent to which he used the latter service is not known.

7.20 Attending appointments also increased his risk of falling as was illustrated by his fall on 13th June 2019 after attending an appointment with DDAS when he was noted to be swaying and unsteady on his feet (Paragraph 5.41). He tripped on a kerb sustaining a head injury which required hospitalisation for four days. Clearly his daily consumption of large quantities of vodka increased his risk of falls. It is assumed that the subdural haematoma which necessitated his admission to the Royal Hallamshire Hospital on 29th August 2019 was also the result of a fall (Paragraph 5.58).

7.21 Adult F also appeared to experience several less serious falls in his own home necessitating the summoning of ambulances. There is no indication that Adult F was referred for a falls risk assessment in respect of falls within the home or that the risk of serious injury or worse from falls whilst mobilising outside the home generated an occupational therapy or safeguarding referral.

7.22 Although they are a largely clinic-based service, DDAS adopted quite an inflexible approach to Adult F's compromised mobility and high risk of falls. Although

they carried out a number of home visits they also required him to attend appointments at their premises when this may have been unsafe. When Adult F requested transportation to his appointment with the DDAS Doctor on 12th June 2019, pointing out that his appointment letter advised him to contact the service should he have any special requirements, he was advised that any PIP benefit he received included an element for mobility (Paragraph 5.39). DDAS could have adopted a more sympathetic approach and considered suggesting a wider range of options including community transport. (DDAS has responded to this paragraph and has stated that they are an entirely clinic based treatment service, adding that their keyworkers hold caseloads of up to 70 clients. DDAS say that it is therefore not possible to offer home visits and in the case of Adult F, the service was flexible to offer some home visits on occasion)

7.23 An inflexible and counter-productive approach was demonstrated by DDAS on 5th July 2019 when Adult F's mother rang them to say that her son was unable to stand or walk and would therefore be unable to collect his medication from the pharmacy (Paragraph 5.44). DDAS advised her that if her son was unable to stand or walk he should summon an ambulance and offered no further assistance. Three days later DDAS confirmed that Adult F had missed prescriptions for the same period of time which necessitated the cancellation of his medications. This disruption in his medication may have been avoided had a home visit been made on the date DDAS was first contacted by Adult F's mother. (DDAS has responded to this paragraph and stated that they would not offer a home visit in these circumstance as they are not a crisis team but it is recognised that the practitioner should have ensured the safety of Adult F by either contacting him or emergency services). Whilst it is appreciated that DDAS may have suspected that Adult F wished to avoid daily visits to the pharmacy for supervised methadone administration, a greater degree of flexibility could have been shown. (DDAS has responded to this point by stating that clients are risk assessed for their suitability and safety to take home their methadone. Following a clinical risk assessment Adult F was assessed as being high risk and he was prescribed daily supervised methadone so that he would be observed taking his methadone in the pharmacy by the pharmacist who could report any concerns to the service).

7.24 All public authorities have a legal duty to make 'reasonable adjustments' to the way they make their services available to people with a disability and to make those services as accessible and effective as possible. Reasonable adjustments may include making whatever alterations necessary to policies, procedures, staff training and service delivery to ensure they work equally well for people with a disability (3). It seems likely that Adult F's compromised mobility would be regarded as a disability under the Equality Act as his compromised mobility appeared to have both a substantial and long term effect on his ability to do normal activities (4).

Safeguarding Referrals

Terms of Reference questions:
Were internal policies and procedures followed at the relevant times by agencies involved in supporting Adult F?
Were the South Yorkshire Safeguarding Adults Policies and Procedures followed and at the relevant times?
Should contextual safeguarding be considered for Adult F?

7.25 Four safeguarding referrals were made in respect of Adult F between May 2019 and his death in December 2019.

7.26 The first safeguarding referral was made by the police on 11th May 2019 after they were called to an incident in which Adult F smashed a neighbour's window whilst intoxicated (Paragraph 5.28). Adult Social Care decided that the three stage test for progressing the police referral to a safeguarding enquiry had not been met primarily because he was considered to be capable of keeping himself safe (Paragraph 5.31).

7.27 Had Adult Social Care had access to the series of 999 calls to the ambulance service on 1st, 6th and 30th March 2019 (Paragraphs 5.22, 5.25 and 5.26) they may have had reason to question whether Adult F was indeed capable of protecting himself from the risk of, or the experience of abuse or neglect. These ambulance service attendances indicated that he may be at risk of self-neglect through excessive alcohol use which on two of the occasions had left him in a collapsed state and unable to get up and had also raised concerns that he was at risk of exploitation by others, although these concerns appear to have proved unfounded on that occasion. Adult Social Care may have taken comfort from the fact that he was receiving support from DDAS, although they were unable to obtain information from DDAS in time to inform the decision to close the safeguarding referral.

7.28 Adult Social Care also decided to forward this first safeguarding referral to the RDASH Adult Mental Health Services Single Point of Access (SPA) which prompted telephone contact between a mental health triage nurse and DDAS 'regarding safeguarding' which was not documented (Paragraph 5.36). This review has been advised that when Adult Social Care decide to share a safeguarding referral with the Adult Mental Health Services SPA there is no system in place for them (Adult Social Care) to receive feedback on the outcome of the SPA's deliberations.

7.29 The second safeguarding referral was made by St Leger Homes six days after the first safeguarding referral (on 17th May 2019). After contacting the Wellbeing Team to check whether Adult F was currently receiving any support from social care, St Leger Homes contacted the Adult Social Care (South) team to raise concerns that Adult F was possibly self-neglecting and were advised to make a referral to ISAT so that Adult F's capacity could be assessed 'to determine if there were any mental health issues affecting his behaviour'. St Leger Homes made this referral (Paragraph

5.32) but it appears to have been subsumed within the first safeguarding referral and may have prompted Adult Social Care to send the safeguarding referral to the Adult Mental Health Services SPA (Paragraph 5.36).

7.30 The third safeguarding referral was made by St Leger Homes on 17th October 2019 after Adult F had been arrested for shouting and swearing at a neighbour and her daughter the day before (Paragraph 5.69 and 5.70). This referral was considered by the Wellbeing Team and ISAT. After checking the Care First information system, the Wellbeing Team concluded that there were a number of agencies (DDAS, Riverside, St Leger Homes and the police) involved with Adult F and therefore there was no role for them. The Wellbeing Team's assumption that a number of agencies were involved with Adult F was incorrect. DDAS had discharged him from their service over a month earlier (Paragraph 5.62) and Riverside had discharged him from their service in March 2019. He was receiving support from St Leger Homes but their focus was primarily on preventing breaches of his tenancy through anti-social behaviour. The only other agencies in contact with Adult F at that time were the police and the ambulance service.

7.31 Conversations with practitioners disclosed that information held on the Care First system does not provide a full picture of service involvement with an individual. Nonetheless it was used by the Wellbeing team to make a key decision about Adult F.

7.32 ISAT concluded that this third safeguarding referral related to criminal damage and 'possible mental health paranoia' and suicidal thoughts but only when Adult F was in drink. The referral stated Adult F to have mental capacity. ISAT appear to have decided that as the presenting issues were largely a police matter and that St Leger Homes were also involved with Adult F, no further action was necessary (Paragraph 5.71). The Association of Directors of Adult Social Services (ADASS) advise that the decision over whether or not to continue to a safeguarding enquiry should be informed by 'proportionate fact finding' (5). Had proportionate fact finding been undertaken at this stage ISAT could have quickly established that Adult F was no longer receiving support from DDAS which might have led to a different outcome. The same ADASS advice states that if it is decided not to progress to safeguarding enquiry any 'residual issues/risks' should be addressed (6). It is not clear how ISAT arrived at the conclusion that any residual issues or risks in respect of Adult F could be addressed by the police and St Leger Homes.

7.33 Additionally, it is unclear what weight was given to the first and second safeguarding referrals in respect of Adult F in deciding that no further action was necessary in response to the third safeguarding referral. This review has been advised that information about safeguarding referrals is stored on EDM (electronic data management) within the Care First system. In theory, this allows patterns to be observed.

7.34 The fourth and final safeguarding referral was made by the police on 2nd December 2019 and received by the Safeguarding Hub two days later. The referral raised concerns about Adult F's intoxication, confusion and mental health. Again it was decided that the three stage test for progressing to a safeguarding enquiry had not been met, specifically that there was no evidence that Adult F was unable to protect himself from harm (Paragraph 5.82). As the safeguarding referral raised concerns about Adult F's mental health, it was again forwarded to the Adult Mental Health Services SPA, where a mental health triage nurse decided that there was no current role for secondary mental health services as Adult F did not have a diagnosed acute mental health problem.

7.35 Had a more complete safeguarding referral been submitted or fuller fact finding been accomplished, it could have been established that Adult F had not been supported by DDAS for over two months, that he had been taken to hospital several times, that his frequent contact with the police and ambulance service presented a very concerning picture of a person in crisis who had recently been the victim of a Hate Crime.

7.36 The response to the safeguarding referrals in respect of Adult F raises concerns over whether sufficient fact finding is completed before a decision is taken not to progress to a safeguarding enquiry on the grounds that the three stage test has not been met. Contact with partner agencies as part of fact finding appeared to be limited and when it was undertaken, there seemed to be a greater imperative to conclude matters quickly rather than an emphasis on making a well-informed decision. The primary source of information appears to be the Care First system which appears to provide a far from complete and up to date picture. Information from some agencies, such as the ambulance service, may not be held on the Care First system.

7.37 Having decided that the three stage test for progressing to a safeguarding enquiry had not been met on three or four occasions over a relatively short period, Adult Social Care could have considered an 'other' safeguarding enquiry if they considered it to be necessary and proportionate to use its powers to make enquiries.

7.38 Two of the four safeguarding referrals were submitted by St Leger Homes. During conversations with practitioners the question of whether safeguarding referrals from housing officers are given as much weight as those received from other professional disciplines was discussed. It was pointed out that housing officers are often the 'eyes and ears' of the safeguarding adults partnership and only tend to make safeguarding referrals when they have exhausted other options.

7.39 In addition to the four safeguarding referrals there were several occasions when further safeguarding referrals could have been made, most notably Adult F's

discharge from hospital on 1st August 2019 when he declined support following the IDT assessment (Paragraph 5.52), his admission to the Royal Hallamshire Hospital on 29th August 2019 with a subdural haematoma (Paragraph 5.58), the series of calls to the ambulance service in March 2019 (Paragraphs 5.22, 5.25 and 5.26), the calls to the police on 25th August 2019 when the police documented him to have 'no carers or anyone to help him' (Paragraph 5.56), many of the escalating calls to St Leger Homes, the police and the ambulance service during October and November 2019, and his self-discharge from hospital against medical advice on 23rd October 2019 (Paragraph 5.72). Additionally, the police documented their intention to make a safeguarding referral after attending two incidents involving Adult F, but did not follow through and actually make the referrals (Paragraphs 5.54 and 5.76).

7.40 The ambulance service appeared particularly reticent about making safeguarding referrals or indeed referrals generally. However it was good practice for the ambulance service to contact Adult F's GP practice on 5th November 2019 (Paragraph 5.78) although they could have considered making a safeguarding referral at this stage as could the GP practice when their MDT met to consider the concerns shared with them by the ambulance service.

Self-Neglect

Terms of Reference question:
What impact did Adult F's mental health, presenting behaviour and lifestyle choices have on proposed interventions and decision making?

7.41 In the FACE assessment carried out by his DDAS key worker in February 2019, Adult F was considered to be neglecting himself, in that he was at risk of malnutrition as he restricted the amount he ate in order to prevent the food 'soaking up the alcohol', as he wished to feel the full effect of the latter (Paragraph 5.13).

7.42 Other than the second safeguarding referral by St Leger Homes which referred to possible self-neglect (Paragraph 5.32), there appeared to be little professional consideration of self-neglect or exploration of invoking the Doncaster Multi-Agency Self-Neglect and Hoarding Policy. This policy defines self-neglect as:

- Lack of self-care - this includes neglect of one's personal hygiene, nutrition and hydration, or health, to an extent that may endanger safety or well-being;
- Lack of care of one's environment - this includes situations that may lead to domestic squalor or elevated levels of risk in the domestic environment (e.g., health or fire risks caused by hoarding);
- Refusal of assistance that might alleviate these issues. This might include, for example, refusal of care services in either their home or a care environment or of health assessments or interventions, even if previously agreed, which could potentially improve self-care or care of one's environment (7).

7.43 Applying this definition to Adult F, he neglected to care for himself by drinking to excess on a daily basis which adversely affecting his memory, his liver and his ability to function. His drinking also put him at high risk of falls which led to serious injuries which compromised his mobility. Concerns arose about the state of his bungalow which was not infrequently described by professionals as unkempt. Additionally, he regularly refused services such as home care (Paragraphs 5.4 and 5.52).

7.44 The Doncaster Self-Neglect Policy applies to people who lack mental capacity, and those people assumed to have capacity and deemed to be making unwise choices. (A discussion of Adult F's mental capacity follows in the next section of this report.) This Policy should be referred to where an adult is deemed to be at risk due to self-neglecting (or hoarding). Adult F's self-neglecting clearly put him at risk of a range of adverse health outcomes including premature death.

7.45 Amongst the principles set out in the Policy is that the most effective approach to self-neglect and/ or hoarding is to use consensual and relationship-based approaches. This type of relationship-based approach was possible during the period Adult F was supported by DDAS, although DDAS were unable to influence Adult F towards a healthier, less risky, lifestyle. Self-neglect research (8) emphasises the importance of gaining insights into the individual's personal history. Adult F's DDAS keyworker was able to explore elements of his personal history but did not appear to gain an understanding of why he drank to excess.

7.46 A further principle set out in the Policy is that 'high risk' is present where there are multiple organisations involved, but their actions are not coordinated and there is no clear oversight and direction or where a person who self-neglects and / or hoards is of concern to numerous different organisations but does not meet their eligibility criteria. Arguably 'high risk' was evident in Adult F's case as once he had been discharged by DDAS there was an absence of 'co-ordination, oversight and direction' and he was deemed to not meet eligibility criteria for the Wellbeing Team, Adult Mental Health services and he repeatedly failed the three stage test for a safeguarding enquiry to be undertaken.

7.47 Attendees at the practitioner learning event arranged to inform this review were of the view that invoking the Multi-Agency Self-Neglect Policy was more likely to lead to a multi-agency approach although the Policy makes clear that self-neglect may not always prompt a Section 42 enquiry, and that an assessment would be made on a case by case basis. A decision on whether a response is required under safeguarding would depend on the adult's ability to protect themselves by 'controlling their own behaviour' (9).

Mental Capacity

Terms of Reference questions:

Was Adult F's mental capacity assessed at the appropriate times? If yes was this recorded, decision specific and timely? What actions were taken as a response to assessments?
Was fluctuating mental capacity considered as an issue and could this have had an impact on the way that services related to Adult F, especially in consideration to substance misuse?
What arrangements and processes were followed when Adult F did not engage or attend appointments?

7.48 Adult F's capacity appeared to fluctuate over the period covered by this review. He was not infrequently deemed to lack capacity to make decisions - such as whether to consent to hospital attendance - due to intoxication.

7.49 Adult F began presenting as confused during July 2019, for example saying he had been in hospital when this was not the case (Paragraph 5.47) and being unable to account for the events of the past few days including travelling to a DDAS appointment the same morning (Paragraph 5.48).

7.50 Later in July 2019 he was found to be suffering from significant memory impairment which was thought to have been caused by alcohol related brain damage (Paragraph 5.49). His DDAS key worker noted that Adult F continued to struggle with his memory, was unable to clearly recollect his actions over recent weeks and was unable to retain new information clearly (Paragraph 5.51).

7.51 Adult F's significant memory impairment should have led to a greater professional focus on his mental capacity thereafter but this does not appear to have been the case. For example, the ward doctor had 'no concerns' about his capacity just prior to hospital discharge on 1st August 2019 (Paragraph 5.52), the 17th October 2019 safeguarding referral from St Leger Homes stated him to have mental capacity (Paragraph 5.71).

7.52 Additionally, following the diagnosis of significant memory impairment, clear opportunities to assess Adult F's mental capacity to make specific decisions appear to have been missed. For example, when he contacted the ambulance service on 11th October 2019, Adult F appeared to be confused and incoherent at times but no capacity assessment appeared to be considered when he declined referrals to social care and alcohol services (Paragraph 5.66), and when he declined treatment or assessment and discharged himself from hospital against medical advice on 23rd October 2019, there is no indication that his capacity to make these decisions was questioned or considered (Paragraph 5.72). However, Adult F was assessed as having the capacity to decline hospital 'crisis team' input on 25th October 2019 (Paragraph 5.73).

7.53 However, there appeared to be no exploration of the mounting number of decisions Adult F was taking to decline services which could be injurious to his physical and mental health. Amongst the unwise decisions Adult F took was the decision to decline home care support on his discharge from hospital on 1st August 2019 (Paragraph 5.52), the decision to discharge himself from hospital against medical advice on 23rd October 2019 (Paragraph 5.72), and his decision to decline hospital 'crisis team' input on 25th October 2019 (Paragraph 5.73).

7.54 The Mental Capacity Act (MCA) sets out five statutory principles which underpin the legal requirements of the Act, one of which is that a person is not to be treated as unable to make a decision merely because they make an unwise decision. However, the MCA Code of Practice states that 'there may be cause for concern if somebody repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character'. The Code of Practice adds that 'these things do not necessarily mean that somebody lacks capacity...but there might be need for further investigation, taking into account the person's past decisions and choices' (10).

Response to Adult F's risk of suicide and self-harm

7.55 Adult F took overdoses of prescription drugs in combination with alcohol on a number of occasions. The most serious incident took place on 31st December 2018 (Paragraphs 5.8 and 5.9). The fact that Adult F had also placed two 10 inch knives down the side of his chair did not appear to be picked up on by the ambulance crew, the hospital or his GP practice. Adult F later disclosed to his DDAS keyworker that he had intended to use the knives to take his own life (Paragraph 5.10). It appears that the seriousness of this incident may not have been fully appreciated by all agencies in contact with Adult F at the time. Additionally, the fact that the overdose involved amitriptyline and possibly other drugs which he was prescribed did not apparently lead to any review of prescribing practice in respect of Adult F.

7.56 He was arrested to prevent him taking an overdose of medication on 25th October 2019 although when he was transferred to hospital later that day he was documented to have taken a 'staggered overdose' over the course of several hours (Paragraph 5.73). He began to talk of 'feeling suicidal' in the series of 999 calls he made to the ambulance service and the police in the weeks prior to his death.

7.57 The reasons why he took or attempted to take overdoses and expressed suicidal ideation went largely unexplored. He appeared to be close to being 'in crisis' during the final weeks of his life, although this did not appear to be fully recognised by agencies at the time. He often declined mental health assessments when he presented at hospital. His close relationship with his mother was seen as a protective factor by DDAS (Paragraph 5.13).

7.58 An audit of suicides in Doncaster conducted between 2013 and 2015 found that the rate of suicide locally remained in line with national data. Of those who took their life, 84% were males, 27% were aged between 51-60 years old, 100% were White British and out of the 37 deaths reviewed, most occurred within the Balby area under the postcode. Adult F was 51 at the time of his death and lived in the Balby area until 2018.

Risk of abuse or exploitation by others including Hate Crime
Terms of Reference question:
What support did services offer Adult F as a victim of abuse by local youths?

7.59 The FACE assessment carried out by Adult F's DDAS keyworker in February 2019 found that his risk of abuse or exploitation by others had fallen following his move to his bungalow in Denaby (Paragraph 5.13). It was acknowledged that he had been physically abused by a 'number of people' in his previous address during the summer of 2016. This is confirmed by his mother's contribution to this review (Paragraph 6.7) although there is no reference to Adult F being a victim of violence in the detailed analysis completed by the police when he was made subject to a POP plan in December 2019.

7.60 Adult F disclosed sexual abuse he had suffered as a child to a liaison and diversion practitioner who established that he had previously been referred to DRASAC (Doncaster Rape and Sexual Abuse Counselling) but had declined their support. (Paragraph 5.18).

7.61 The smashing of the front bay windows of his bungalow whilst he was in police custody on 16th October 2019 (Paragraph 5.69) may have been an indicator of a degree of hostility towards him which may have been connected to his involvement in incidents of anti-social behaviour locally.

7.62 Incidents which indicated hostility towards him on the grounds of his sexuality began to be reported from 31st October 2019 when he reported children shouting 'nonce' which he perceived to have been directed at him (Paragraph 5.76) and which he was documented as saying was an 'ongoing issue' which implied that this was not the first such incident. This incident does not appear to have been treated as a potential hate crime although a subsequent incident on 30th November 2019 was recorded as a hate crime. On this occasion Adult F reported that three youths had called him a 'fucking faggot' and thrown a bottle at him (Paragraph 5.80). However the hate crime was closed pending further evidence coming to light despite Adult F telling the police that he knew the names of two of the youths. The associated crime of common assault (bottle also thrown at Adult F by the youths) remained under investigation at the time of Adult F's death.

7.63 It seems possible that Adult F's reports of crimes against himself may been given insufficient weight because his account of events often appeared confused and he was regarded as a 'major cause of anti-social behaviour on his street' (Paragraph 5.76). Clearly Adult F's behaviour towards some of his neighbours was very concerning but the perception of him as a perpetrator may have obscured the risks he faced as a potential victim of violence, notwithstanding the fact that the police added a vulnerable person marker to their call recording system in respect of Adult F (Paragraph 5.57).

Multi-Agency Working

Terms of Reference questions:
Was information shared appropriately between agencies? In particular regarding Adult F as a vulnerable adult and a victim of abuse.
Did agencies work in an assertive and proactive way, giving consideration to legal options?

7.64 Overall, multi-agency working was not effective. However, several agencies worked well with a second agency such as the Wellbeing Team following on from STEPS after Adult F's stroke in 2017/2018, the liaison between DDAS and the hospital DANS on occasions and the police and St Leger Homes in response to concerns about anti-social behaviour by Adult F.

7.65 However no multi-agency meeting or discussion appears to have taken place as concerns about Adult F began to escalate. Had any of the safeguarding referrals progressed to a safeguarding enquiry this could have provided a framework for multi-agency collaboration.

7.66 The decision by the police to adopt a Problem Oriented Policing approach shortly before Adult F's death had the potential to promote multi-agency working although the focus was primarily on reducing the demands that Adult F was making on the police, the ambulance service and St Leger Homes.

7.67 Agencies appeared slow to adjust the support they provide to Adult F when his needs changed or when other agencies discharged him. For example St Leger Homes continued to focus on tenancy management as opposed to tenancy support even after Riverside, who appear to have been providing tenancy support, ceased to be involved with Adult F. However, St Leger Homes have advised this review that they received no notification that Adult F was no longer being supported by Riverside or indeed DDAS. The DDAS recovery plan (Paragraph 5.24) included the support Adult F was receiving from Riverside as an asset despite the fact that Riverside were in the process of discharging him. Additionally, Adult F's GP practice did not appear to pick up on the fact that Adult F was largely unsupported following his discharge

from hospital on 18th September 2019 and consider what follow up they should consider.

7.68 The police became aware that Adult F may be using illicit drugs on one occasion (Paragraph 5.16) and could have considered notifying DDAS who had earlier assessed him to have been illicit drug-free for two years.

Prevention

7.69 One of the six key principles which underpin safeguarding work is prevention - in that it is better to take action before harm occurs. Adult F had complex and deteriorating health conditions and was on a clear downward trajectory. Combined with his history of refusal of services and lack of self-care, it was predictable that Adult F would eventually be at a point where he would require greater support.

7.70 Although Adult F declined support from Adult Social Care on more than one occasion, if he had been recognised to be self-neglecting, the Care and Support Statutory Guidance states that 'where the adult who is or is at risk of abuse or neglect has capacity and is still refusing an assessment, local authorities must undertake an assessment so far as possible and document this. They should continue to keep in contact with the adult and carry out an assessment if the adult changes their mind, and asks them to do so' (11). As self-neglect is considered to be a category of abuse or neglect as set out in the Care Act 2014, it would have been appropriate for professionals to have made a referral to social care without Adult F's expressed consent once it was determined he was self-neglecting.

Good practice

7.71 Adult F's keyworker got to know him quite well and conducted a thorough FACE assessment which highlighted many of the risks which later materialised.

7.72 On 27th February 2019 DDAS reported Adult F missing to the police who found him safe and well in his home address later the same day. It was good practice to continue to try and locate the patient and appropriate to escalate the matter to the police.

7.73 The contact with Adult F's GP on 5th November 2019 to raise concerns was an appropriate action which could have led to a multi-agency discussion.

7.74 During the period under review, Adult F was arrested and detained by the police on several occasions. During these periods in custody, Adult F was seen by the Liaison and Diversion practitioner who was instrumental in ensuring the police made safeguarding referrals on two occasions (Paragraphs 5.28 and 5.69).

8.0 Findings and Recommendations

8.1 This review discloses that in the months prior to Adult F's violent death his vulnerability to abuse and neglect was increasing at a time when his support from services was falling away and he was increasingly seen as a perpetrator of anti-social behaviour and a person who was making excessive demands on emergency services.

8.2 The review focusses primarily on the final year of Adult F's life but it is acknowledged that many of the issues affecting his life were of longstanding and there may have been earlier opportunities to prevent or delay his clear downward trajectory which it has not been possible to explore in this review.

Care and treatment of Adult F's harmful alcohol use

8.3 DDAS had been supporting Adult F for a number of years and knew him well. He benefitted from a keyworker who thoughtfully assessed the risks he faced and attempted to engage him in changing his relationship with alcohol. However, after Adult F's discharge following the hospital detox there was an opportunity for DDAS and partner agencies to play a role in post detox support but this did not happen.

8.4 Additionally, the decision to discharge Adult F from DDAS without making efforts to locate him and check on his welfare was unsatisfactory and carried risks. (It is not known whether a risk assessment was carried out at the point of discharge). It would also have been helpful if DDAS had considered informing other agencies of their decision to discharge Adult F who were providing support to Adult F including St Leger Homes, his social landlord. This discharge was turning point in the overall care and support provided to Adult F and, given his tenuous link to primary care, left him isolated from support services.

8.5 It is therefore recommended that the Safeguarding Adults Board seeks assurance over the process by which patients are discharged from DDAS, in particular that any risks are assessed and addressed and that other agencies working with the patient are notified.

Recommendation 1

That Doncaster Safeguarding Adults Board seeks assurance from Rotherham Doncaster and South Humber NHS Foundation Trust in respect of the process by which patients are discharged from DDAS, in particular that any risks are assessed and addressed and that other agencies working with the patient are notified.

Hospital discharges

8.6 Notification to DDAS of Adult F's discharges from hospital was inconsistent and appeared to largely depend on the involvement of the hospital's Drug and Alcohol Nurse Specialist (DANS). The lack of notifications to DDAS adversely affected continuity of care for Adult F and rendered two hospital discharges unsafe (Paragraphs 7.7 and 7.9). Additionally, it might have expected that Magnolia Lodge would have made contact with DDAS when they were considering Adult F's suitability for neurorehabilitation given that they were aware that he was 'well known' to addiction services

8.7 Adult F's Admission to an out of area hospital – the Royal Hallam Hospital in Sheffield – also appeared to adversely affect notification of his admission and subsequent repatriation to Doncaster.

8.8 It is therefore recommended that the Safeguarding Adults Board seeks assurance from Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust that all relevant agencies will be involved in discharge planning. Assurance should also be sought from Rotherham Doncaster and South Humber NHS Foundation Trust that the Magnolia Lodge consults relevant community based services when appropriate. Additionally, the Safeguarding Adults Board may wish to explore whether relevant local services are informed when a Doncaster resident is admitted to an out of area hospital.

Recommendation 2

That Doncaster Safeguarding Adults Board seeks assurance from Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust that all relevant agencies will be involved in discharge planning. Assurance should also be sought from Rotherham Doncaster and South Humber NHS Foundation Trust that the Magnolia Lodge consults relevant community based services when appropriate.

Recommendation 3

That Doncaster Safeguarding Adults Board explores the extent to which relevant local services are informed when a Doncaster resident is admitted to an out of area hospital.

Lack of follow up by Adult F's GP practice

8.9 Adult F's GP practice made only limited attempts to follow up on his many hospital attendances and admissions. The practice did not explore why Adult F was not attending GP appointments, which might have led to a transfer to a more geographically convenient practice and possibly reduced his reliance on the 999

system to contact the ambulance and police services with issues which could have been resolved by primary care.

8.10 When the GP practice was contacted by the ambulance service on 5th November 2019 to express concerns about Adult F, one might have anticipated a more proactive response to the ambulance service concerns and possibly the consideration of a safeguarding referral, given that the GP practice held a substantial amount of information about Adult F, including the fact that he had been discharged from DDAS after many years of support.

8.11 It is therefore recommended that the Safeguarding Adults Board obtain assurance over the process by which GP practices monitor and support vulnerable patients such as Adult F.

Recommendation 4

That Doncaster Safeguarding Adults Board obtains assurance from Doncaster Clinical Commissioning Group over the process by which GP practices monitor and support vulnerable patients such as Adult F.

Adult F's compromised mobility and risk of falls

8.12 Adult F's compromised mobility and high risk of falls made it challenging for him to attend appointments. At times DDAS adopted quite an inflexible approach to this issue and Adult F's GP practice did not appear to make a link between his compromised mobility and the fact that the practice was situated 13 miles away from his home when responding to his failure to attend appointments.

8.13 All public authorities have a legal duty to make 'reasonable adjustments' to the way they make their services available to people with a disability, to make those services as accessible and effective as possible. It seems likely that Adult F's compromised mobility would be regarded as a disability under the Equality Act.

8.14 Additionally, Adult F's high risk of falls inside and outside his home did not appear to generate any falls risk assessments. At 51, he was much younger than the age groups usually considered to be at greatest risk of falls and policies tend to focus on falls in the home or in settings such as hospitals.

8.15 It is therefore recommended that when the learning from this case is disseminated, the Safeguarding Adults Board draws the attention of professionals to the need to make reasonable adjustments for service users with a disability and draws attention to falls risk policies.

Recommendation 5

That when the learning from this case is disseminated, Doncaster Safeguarding Adults Board draws the attention of professionals to the need to make reasonable adjustments for service users with a disability and draws attention to falls risk policies.

Safeguarding Referrals

8.16 The response to the safeguarding referrals in respect of Adult F raises concerns over whether sufficient fact finding is completed before a decision is taken not to progress to a safeguarding enquiry on the grounds that the three stage test has not been met. Contact with partner agencies as part of fact finding appeared to be limited in this case and when it was undertaken, there seemed to be a greater imperative to conclude matters quickly rather than an emphasis on making a well-informed decision. The primary source of information for fact finding appears to be the Care First system which seems to provide a far from complete and up to date picture. Information from some agencies, such as the ambulance service, may not be held on the Care First system.

8.17 Had fuller fact finding been achieved in this case, it could have been established that Adult F was no longer being supported by DDAS, that he had been taken to hospital several times, that his frequent contact with the police and ambulance service presented a very concerning picture of a person in crisis who had recently been the victim of a Hate Crime.

8.18 It is therefore recommended that the Safeguarding Adults Boards develops a system for reporting and analysing activity related to safeguarding adults concerns which do not meet the statutory duty to carry out a S42(2) enquiry, so that they can assure themselves of the types of concerns being received, the responses made and the outcomes for the adults concerned.

Recommendation 6

That Doncaster Safeguarding Adults Board develops a system for reporting and analysing activity related to safeguarding adults concerns which do not meet the statutory duty to carry out a S42(2) enquiry, so that they can assure themselves of the types of concerns being received, the responses made and the outcomes for the adults concerned.

Self-Neglect

8.19 Adult F's self-neglecting clearly put him at risk of a range of adverse health outcomes including premature death. However, there appeared to be little professional consideration of self-neglect or exploration of invoking the Doncaster

Multi-Agency Self-Neglect and Hoarding Policy. Attendees at the practitioner learning event arranged to inform this review were of the view that invoking the Multi-Agency Self-Neglect Policy would have been more likely to lead to the adoption of a multi-agency approach.

8.20 It is therefore recommended that when the learning from this review is disseminated, the Safeguarding Adults Board ensures that self-neglect is highlighted together with the opportunities to invoke the Multi-Agency Self-Neglect and Hoarding Policy in Adult F's case.

Recommendation 7

That when the learning from this review is disseminated, Doncaster Safeguarding Adults Board ensures that self-neglect is highlighted together with the opportunities to invoke the Multi-Agency Self-Neglect and Hoarding Policy in Adult F's case.

Mental Capacity

8.21 One might have expected Adult F's significant memory impairment to have led to a greater professional focus on his mental capacity thereafter but this does not appear to have been the case as clear opportunities to assess Adult F's mental capacity to make specific decisions appear to have been missed. Additionally there appears to have been no exploration of the mounting number of 'unwise' decisions Adult F was taking to decline services - which could be injurious to his physical and mental health.

8.22 The Mental Capacity Act has proved a challenging piece of legislation for professionals to come to terms with and invariably appears as a learning theme in Safeguarding Adults Reviews. This review is no exception. It is therefore recommended that the Safeguarding Adults Board requests each agency involved in Adult F's case to state what specific actions they plan to take in the light of this SAR to improve the response of their staff to mental capacity issues including the issue of someone persistently making unwise decisions.

Recommendation 8

That Doncaster Safeguarding Adults Board requests each agency involved in Adult F's case to state the specific actions they plan to take in the light of this SAR to improve the response of their staff to mental capacity issues including the issue of someone persistently making unwise decisions.

Response to Adult F's risk of suicide and self-harm

8.23 Adult F took overdoses of prescription drugs in combination with alcohol on a number of occasions. The most serious incident took place on 31st December 2018 (Paragraphs 5.8 and 5.9). Information sharing about the incident was incomplete and the fact that the overdose involved amitriptyline and possibly other drugs which he was prescribed did not apparently lead to any review of prescribing practice in respect of Adult F.

8.24 It is therefore recommended that the learning from this review about the response to Adult F's attempt to take his own life is shared with those responsible for the Doncaster Suicide Prevention Plan, so that it can inform awareness raising around professional actions to take in response to apparent suicide attempts.

Recommendation 9

That Doncaster Safeguarding Adults Board shares the learning from this review about the response to Adult F's attempt to take his own life with those responsible for the Doncaster Suicide Prevention Plan, so that it can inform awareness raising around professional actions to take in response to apparent suicide attempts.

Risk of abuse or exploitation by others including Hate Crime

8.25 It seems possible that Adult F's vulnerability to abuse or exploitation by others may have been masked by the perception that he was a perpetrator of anti-social behaviour and something of a 'nuisance' in his repeated use of the 999 system to seek assistance from the police and the ambulance service.

8.26 It is therefore recommended that when the learning from this review is disseminated, the Safeguarding Adults Board ensures that the issue of how negative perceptions of Adult F may have obscured his vulnerability is highlighted.

Recommendation 10

That when the learning from this review is disseminated, Doncaster Safeguarding Adults Board ensures that the issue of how negative perceptions of Adult F may have obscured his vulnerability is highlighted.

Multi-Agency Working

8.27 No multi-agency meeting or discussion appears to have taken place as concerns about Adult F began to escalate. Had any of the safeguarding referrals progressed to a safeguarding enquiry this could have provided a framework for multi-agency collaboration. Additionally, agencies appeared slow to adjust the support they provide to Adult F when his needs changed or when other agencies discharged

him. Improved multi-agency working may also have prevented or reduced the need for so many hospital admissions for Adult F.

8.28 It is therefore recommended that when the learning from this review is disseminated, the Safeguarding Adults Board ensures that the benefit of multi-agency meetings or discussions is highlighted.

Recommendation 11

That when the learning from this review is disseminated, Doncaster Safeguarding Adults Board ensures that the benefit of multi-agency meetings or discussions is highlighted.

Adult F's voice

8.29 Although Adult F's DDAS key worker got to know him quite well, there appeared to be insufficient exploration of Adult F's personal history in an effort to understand why he drank alcohol to excess, leading to self-neglect and the risk of serious harm and premature death. Attendees at the practitioner learning event arranged to inform this review felt that Adult F was 'voiceless'.

9.0 References

(1) Retrieved from https://www.nhs.uk/conditions/alcohol-misuse/treatment/

(2) Retrieved from https://www.england.nhs.uk/2019/01/missed-gp-appointments-costing-nhs-millions/

(3) “The Essential Guide to the Public Sector Equality Duty” (2014) Equality and Human Rights

(4) Retrieved from https://www.gov.uk/definition-of-disability-under-equality-act-2010

(5) Retrieved from https://www.adass.org.uk/media/7326/adass-advice-note.pdf

(6) ibid

(7) Retrieved from https://dmbcwebstolive01.blob.core.windows.net/media/Default/AdultSocialCare/Doncaster%20Multi-agency%20Policy%20Self-Neglect%20and%20Hoarding%20V2.2.pdf

(8) Braye, S., Orr, D. and Preston-Shoot, M. Self-neglect Policy and Practice: Building an Evidence Base for Adult Social Care. London: Social Care Institute for Excellence. http://www.scie.org.uk/publications/reports/report69.asp

(9) Retrieved from https://dmbcwebstolive01.blob.core.windows.net/media/Default/AdultSocialCare/Doncaster%20Multi-agency%20Policy%20Self-Neglect%20and%20Hoarding%20V2.2.pdf

(10) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

(11) Retrieved from https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1