Safeguarding Adults Review

“Martin”

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Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

Contents

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Introduction

In November 2019, Martin (a pseudonym has been used to protect anonymity) was discovered, deceased, in a park in Leicester.

There is no indication that Martin's death resulted from abuse or neglect and there was no requirement under the Care Act 2014 to undertake a review of this case. Nonetheless, Leicester Safeguarding Adults Board (SAB) chose to undertake this review. It was thought that a review of Martin's circumstances prior to his death, focused on access to rehabilitation services after detoxification where there are pending criminal justice proceedings, would provide useful insights for future practise. By promoting effective learning and improvement action, Leicester Safeguarding Adults Board (LSAB), aims to prevent future deaths or serious harm occurring.

Summary of learning themes

This review explores a number of themes that emerged from the analysis of organisational involvement with Martin:

- Access to alcohol and substance misuse rehabilitation when criminal justice proceedings are pending
- Agency engagement with the Vulnerable Adult Risk Management (VARM) process
- Communication between organisations

Context of Safeguarding Adults Reviews

One of the core duties of a Safeguarding Adults Board (SAB), under Section 44 of the Care Act 2014, is to review cases in its area (in this instance, Leicester) where an adult with needs for care and support (whether or not the Local Authority was meeting these needs):

- has died and the death resulted from abuse and neglect, or
- is alive and the SAB knows or suspects that they have experienced serious abuse or neglect

Importantly, Safeguarding Adults Reviews (SARs) are about how agencies worked together to safeguard adults; they are in their nature multi-agency reviews. For a review to be mandatory in legislation, there must be reasonable cause for concern about how the SAB, its members, or others with relevant functions worked together to safeguard the adult.

How this case met the safeguarding adults review criteria

It was the view of Leicester SAB's Review Subgroup and Independent Chair that, at the time of commissioning this review, the case did not meet the criteria for a mandatory Safeguarding Adults Review (SAR) under the Care Act 2014. However, it was agreed that there may be useful learning for the safeguarding partnership and therefore a SAR was commissioned under Section 44(4) of the Care Act 2014, which allows for a non-mandatory SAR to be undertaken in the following circumstances:

'An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).'

At the time of commissioning the review, the partnership asked that the review focus on the following:

- to look specifically at the relevant policy for agencies in respect of access to rehabilitation services when there are ongoing criminal justice proceedings.

Succinct summary of case

Leicester Safeguarding Adults Board (SAB) initiated this Safeguarding Adults Review (SAR) in March 2020. It followed the police being called out to a local park by East Midlands Ambulance Service where the body of a man in his thirties, Martin, had been found by a park warden and a member of the public. There were no suspicious circumstances.

Martin was alcohol dependent and his consumption had escalated, with professionals considering that it had become high risk. Martin was receiving support from a specialist alcohol and substance misuse provider and adult social care at the local authority had become involved to enable Martin to access rehabilitation. He had completed his detoxification placement at the time of his death but, due to an outstanding charging decision by the courts, Martin's entry into a rehabilitation programme was being delayed. Upon discharge from inpatient detoxification, into a hostel, Martin immediately relapsed and resumed his alcohol consumption.

Martin was known to a number of organisations. He had a long history of Police involvement, mainly in relation to domestic incidents at his former home address where he had lived with his parents, and knife possession. Martin was under the supervision of the local probation community rehabilitation company at the time of his death, due to a previous conviction. Martin was a frequent user of health services, presenting with health conditions related to excessive alcohol use, and had also been

involved with mental health services where he often displayed suicidal ideation when intoxicated. His GP was involved in Martin's care, with close contact maintained with the alcohol and substance misuse provider, with records suggesting that he had over 20 attendances at the emergency department of the local hospital between May and November 2019, some of which ended in admission, including two to intensive care. East Midlands Ambulance Service (EMAS) have recorded 12 callouts to Martin from May to November 2019, all of which resulted in him being transported to the emergency department of the local hospital.

Martin's alcohol and substance misuse provider was particularly concerned about the increasing risks to Martin in terms of his self-neglect linked to alcohol misuse. A strategy meeting was held on 21 October, followed by a Vulnerable Adult Risk Management (VARM) meeting on 25 November, with a number of relevant organisations invited. A number of key organisations who were invited and asked to contribute information did not attend the VARM meeting and did not supply information to inform the decision-making at the meeting.

The hostel that Martin was supposed to be staying at upon completion of his inpatient detoxification, from 5 November, did not allow alcohol on the premises so the only way he could continue to drink was to do so elsewhere. Risks were flagged with Martin in discussion with his alcohol support worker that if he collapsed outdoors he would be at risk of hypothermia.

In the three weeks leading up to his death, Martin had drunk to a level of 120+ units per day prompting admissions to the hospital intensive care unit and almost loss of life. When the consequences of continued drinking at this level were discussed with him in hospital, he stated, 'no concern', 'not bothered' and expressed having nothing to live for. A full Mental Health Assessment was requested and the referral was to be completed that day. Although Martin was initially agreeable to this assessment, he later stated he did not want it and left the ward. He was readmitted within a couple of hours that afternoon, on the 28 November, but later self-discharged, again before any assessment could be undertaken.

On the morning of the 29 November, the hostel staff called the specialist alcohol and substance misuse provider to say that Martin had been discharged from hospital at approximately 6:45pm the previous day but had not returned to the hostel and they were concerned for his safety. Martin's body was found later that morning.

Terms of reference

The terms of reference for this review were to carry out a piece of work focused specifically on local access to rehabilitation services after detox where there are pending criminal justice proceedings. Information provision was limited to organisational contact with Martin during the scoping period, covering the 6 months

leading up to his death, as well as any relevant single or multi-agency policies and procedures.

Methodology

Due to the limited scope of the review, the methodology selected by the partnership was that of a desktop review of information supplied by organisations who had involvement with Martin. Specific organisations were required to provide details of any policies and explanations of approaches adopted to address circumstances where a person deemed ready to access a rehabilitation programme is subject to criminal justice proceedings which have yet to be finalised. The review was then completed 'in house' with the LSAB Board officer undertaking the desktop review and authoring the report.

Engagement with the family

Leicester Safeguarding Adults Board recognises the invaluable contributions family members can make to a review. For this review, the LSAB Board Office has contacted Martin's family who agreed to have some involvement with the review.

Review team

The Review Team consisted of members of Leicester Safeguarding Adults Board's Review Subgroup, which included senior safeguarding representatives from the following agencies:

- Leicestershire Police
- DLNR Community Rehabilitation Company
- Leicestershire Partnership NHS Trust
- University Hospitals of Leicester NHS Trust
- Leicester City Adult Social Care
- Leicester City Clinical Commissioning Group
- Leicester City Housing Service
- Leicestershire Fire and Rescue Service
- National Probation Service

Review timeline

Care Act 2014 statutory guidance identifies that Safeguarding Adults Reviews should be completed 'within 6 months of initiating it, unless there are good reasons for a longer period being required '. In this instance, the review took 4 months from commissioning to the Overview Report being drafted. All agencies worked well together to ensure this review was completed within a reasonable timeframe, so that learning can be progressed whilst it remains current.

Milestone	Completion date
SAR REFERRAL RECEIVED	February 2020
Referral heard at Review Sub Group	February 2020
Trawling letters issued	February 2020
Trawl returns	March 2020
Review Subgroup recommendation to commission a SAR	March 2020
Recommendation put to Independent Chair	March 2020
SAR COMMISSIONED	March 2020
Methodology agreed	March 2020
Agencies provided information and policies	June 2020
Board Office initiate engagement with family	June 2020
Board Office undertake desktop review	June 2020
OVERVIEW REPORT DRAFTED	July 2020

Desktop review findings and analysis

A number of key organisations involved with Martin were asked to provide their written policies and processes which encompassed what approach should be taken when someone deemed ready for alcohol or substance misuse rehabilitation has pending criminal justice proceedings. Responses from all the organisations confirmed that there was no existing written policy or process and that the local approaches taken were informal and not contained in any policy.

Organisation	Description of approach
Alcohol and substance misuse service	*Our understanding of this policy is based on 12 years managing Criminal justice and community treatment services and is that those who have any pending criminal convictions cannot be considered for residential rehab whilst they have these matters pending. The reason for this in our understanding is that as the individual will be in court in the near future and may get either a custodial sentence or community based sentence with probation requirements, they cannot go to rehab as their stay at rehab may be interrupted and cut short which would have both a detrimental impact on their recovery and also a financial impact as the placement would already be being funded.*
Adult Social Care	*There is no guidance/process around people on bail but we do not place anyone in rehab until we know the outcome of the legal process. Presumably we couldn't anyway as they'll have been bailed to a specific address. If someone's on a community order their probation officer may agree to a move to rehab and transfer them to the Probation team wherever the rehab is but that's obviously further down line. We do also make a number of admissions to rehab directly from prison.*
Local CRC Probation	*My understanding is that whilst there are matters outstanding that could result in a custodial sentence, admission to rehab is unlikely to occur given the placement could be interrupted. However, this is solely based on anecdotal experience rather than explicit policy/guidance.*

The lack of a clear process or policy is problematic on a number of levels:

- Unclear or inconsistent decision-making which may not be in the best interests of the person using services
- No built-in risk management process for the individual or process maps to support practitioners
- Reliance on 'word of mouth' historical approaches which may be outdated
- Lack of clarity of the role of each organisation resulting in misunderstandings and conflict
- Decision-making from one organisation impacting on another organisation's ability to manage risks to the person using services

For Martin, although he had completed his detoxification placement, his planned residential rehabilitation was being delayed pending resolution of his criminal justice matters. This meant that Martin was discharged from inpatient detoxification to a local hostel. Martin unfortunately began to drink again as soon as he returned to Leicester.

In conclusion, there is no existing multi-agency policy or procedure to cover circumstances when a person is deemed ready to access rehabilitation services but has criminal justice matters which have yet to be concluded.

Good Practice identified:

- Services negotiated with the detoxification service provider to extend the inpatient stay until hostel accommodation could be arranged so that Martin would not be homeless on his return
- Martin's relative was included in the VARM process, having been invited to, and attended, the VARM meeting.

System findings

Policies and procedures for alcohol and substance misuse rehabilitation when the person has pending criminal justice proceedings

Case finding: Organisations did not have access to a policy or guidance to support them in considering rehabilitation access for Martin.

System finding: There is no formal local policy or procedure to guide professionals in the situation where someone who has completed detoxification is ready to access alcohol or substance misuse rehabilitation services but has pending criminal justice proceedings. This meant that, for Martin, organisations adopted a blanket approach that they do not place anyone in rehabilitation until the outcome of the legal process is known.

Attendance at Vulnerable Adult Risk Management (VARM) meetings

*Case finding: Key o*rganisations did not attend the VARM meeting set up to discuss the risks to Martin and to formulate strategies to manage those risks.

System finding: Key organisations did not provide representation at the VARM meeting and did not provide information in advance of the meeting to contribute to discussion and risk management.

In this case, the key agencies were Police, Adult Social Care, the GP and Probation Community Rehabilitation Company (CRC).

It is unclear whether attendance was pursued by the alcohol and drugs misuse service provider, who organised the VARM meeting, or whether the minutes had been distributed to invitees, whether they attended or not, as part of post-meeting actions. It is noted, however, that the VARM meeting was held on 25 November and Martin died on 29 November, giving little time for minutes to be finalised and circulated nor for actions to be followed-up.

Multi-agency recommendations

Theme	Recommendation	Responsible Organisation
Policy or process for alcohol or substance misuse rehabilitation when the person using services is awaiting a criminal justice charging decision	Multi-agency practice guidance should be produced to govern decision-making, and the role of organisations, when a person deemed ready to enter alcohol or substance misuse rehabilitation is awaiting a criminal justice charging decision. This should cover circumstances including: when rehabilitation should, and should not, be delayed risk mitigation plans to manage risks to a person during any delay in accessing the planned rehabilitation placement.	Alcohol and substance misuse service provider Adult Social Care
VARM meeting attendance	The organisations who did not attend the VARM meeting should be asked to review their organisational response and provide assurance that it was in line with the LLR VARM policy, encompassing the points below and giving consideration to sharing any learning internally: Whether attendance should have been prioritised If attendance should not have been prioritised, whether information relevant to managing risks to Martin could have been shared in advance of the meeting to aid decision-making Whether the correct staff were invited, for example allocated workers, and whether the reasons for required attendance were explored prior to the meeting.	Police GP CRC Probation Adult Social Care

Appendix 1: Combined chronology of key events

Timeline

Date	Description
March 2019	Martin referred into alcohol misuse treatment and was offered an assessment appointment to re-enter treatment. He then failed to attend for two scheduled assessment appointments
April 2019	Assault on mother and criminal damage at family home Martin appeared at Leicester Magistrates Court and was sentenced to a 12-month Community Order with a 6-month Alcohol Treatment Requirement (ATR) and 10 days Rehabilitation Activity Requirement (RAR). The case was assessed as posing a medium risk of harm and medium likelihood of reoffending.
June 2019	Martin attended his alcohol misuse service appointment intoxicated making threats to harm his parents. Reported to his parents and Police. Martin is arrested for possession of knives Martin appeared at Leicester Magistrates Court for a further offence and was sentenced to a concurrent 12-month Suspended Sentence Order comprising of 3 months suspended imprisonment and a further 5 days RAR (Statutory Alcohol Treatment Requirement delivered by a specialist alcohol and substance misuse provider.
July 2019	A referral was made to the local authority Substance Misuse Team by the alcohol and substance misuse provider requesting an assessment for residential rehabilitation.
September 2019	Martin was arrested for damage at his parents address. He was arrested and released on bail with conditions for a CPS decision. The local authority Substance Misuse Team worker arranged a screening assessment for a 14-day detox with Martin and the alcohol and substance misuse provider to attend.
October 2019	Professionals Meeting arranged to be attended by the various agencies/professionals involved in Martin's care and treatment with a view to collectively plan a way forward to support and safeguard him. It was decided that action would be taken forward by way of a Vulnerable Adult Risk Management (VARM) meeting. Police advised Martin was in police custody due to threats made against his parents. Martin enters inpatient detox and the provider agrees to extend it so that he could remain there until November 2019 when a place at a hostel had been confirmed for post detox discharge.

November 2019	Services are advised that Martin has fully relapsed. A VARM meeting was held with attendance from various professionals. Martin is found deceased.

Appendix 2: Key to acronyms and abbreviations

Abbreviation	Full name
ASC	Adult Social Care
CRC Probation	Community Rehabilitation Company Probation
EMAS	East Midlands Ambulance Service
GP	General Practitioner
LSAB	Leicester Safeguarding Adults Board
SAR	Safeguarding Adults Review
VARM	Vulnerable Adult Risk Management