SAFEGUARDING ADULT REVIEW
Overview Report

Review into the death of “LILY”, who died in March 2021 in Bristol

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SAFEGUARDING ADULT REVIEW

Keeping Bristol Safe Partnership

1. INTRODUCTION

1.1. Lily was a 30 year old white British heterosexual woman who was found in cardiac arrest by a member of the public in the early hours of the morning in March 2021, outside the Bristol Royal Infirmary. Efforts to resuscitate Lily were unsuccessful and she was pronounced dead. Lily had an extensive history of contact with services and especially with the criminal justice system and was homeless at the time of her death.

2. SAFEGUARDING ADULT REVIEWS

2.1. Section 44 of the Care Act 2014 places a statutory requirement on the Bristol Adult Safeguarding Partnership Board (known as the Keeping Bristol Safe Partnership (KBSP)) to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on the KBSP the power to commission a SAR into any other case:

'A review of a 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) if –

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

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).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –
a) identifying the lessons to be learnt from the adult's case, and
b) applying those lessons to future cases.

2.2. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

2.3. The KBSP members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.4. This case was referred to the SAR Sub-group of the KBSP in March 2021 and considered for a Safeguarding Adult Review at a meeting in April 2021.

2.5. The SAR Sub-group recommended that this case met the criteria for a discretionary SAR at a scoping meeting held in April 2021, and the Independent Chair of the Board ratified this in June 2021. A discretionary SAR was agreed because the Board felt that a review into this case would bring out valuable learning with regards to working with people who experience multiple disadvantages.

2.6. The Safeguarding Adults Review was led by Patrick Hopkinson who is an Independent Consultant in Adult Safeguarding and who had no previous involvement with this case and no connection to the KBSP, or its partner agencies.

2.7. **The review**

2.8. This Safeguarding Adults Review involved the creation of a combined chronology, panel meetings and a practitioners' session. The practitioners' session was attended by representatives from the Probation Service, Avon and Somerset Police and University Hospital Bristol and Weston NHS Trust. This was a small number but allowed in depth discussion of key events and factors in the response of services to Lily.

2.9. The review was originally commissioned in 2021 to include a short summary report followed by development work to implement the key findings of the review. The focus was on identifying areas for, and initiating, change. As a result, the review would use annotated chronological information and discussions with practitioners rather than more extensive individual management reviews and additional records. Further information would be gathered if necessary to prompt and support practice change.

2.10. The review began but was delayed by the response to Covid-19 and changing organisational circumstances. As a result of this, a decision was made by the KBSP to focus only on the production of the report based on the annotated chronology and learning from the practitioners' session. Consequently, this report analyses this information and draws from practice guidance, other Safeguarding Adults Reviews and research in order to support practice development.

2.11. **Terms of reference**

2.12. The following terms of reference were chosen by the Safeguarding Adults Review panel to guide the review:

- How organisations responded to Lily and understood her needs.
- How was Lily's mental capacity understood?

- How was Lily's mental health understood?
- How was Lily's homelessness understood?
- Were there any barriers to practice, including for example, eligibility criteria, discharge criteria, conscious or unconscious biases in judgements about lifestyle choice, personal responsibility etc, recognition and response to self-neglect and mental health needs, etc.
- Were there examples of good practice and facilitation of good practice?
- How effectively did organisations communicate, share and use information?
- How effectively did organisations work together?
- Did inequalities impact on access to, and the response by, services to Lily?
- What lessons can learn and how can we turn these into recommendations for change including how to embed system change based on system flex?

3. BRIEF SUMMARY OF CHRONOLOGY AND CONCERNS

3.1. The following services were involved with Lily during the time covered by the chronology, 1st January 2020 – March 2021:

- Medical Centre (GP)
- Bristol City Council - Housing & Landlord Service
- Avon and Somerset Constabulary
- University Hospital Bristol and Weston NHS Trust
- Bristol City Council – Support planning brokerage
- Probation Service
- Avon and Wiltshire Mental Health Partnership
- Bristol City Council - Homeless Move on Team (Adult Social Care)
- Bristol City Council - Access and Response team

3.2. Due to the number of contacts with and about Lily this chronology will provide a summary and then will focus on key events. Table 1 shows the number of contacts with different agencies between 1st January 2020 and March 2021.

Table 1: Number of contacts with Lily by different agencies between 1st January 2020 and March 2021

Agency /organisation	**Total contacts**	**Direct contact with Lily (eg face to face or by telephone)**	**Contacts episodes or referrals between agencies concerning Lily**	**Failed contacts**
Medical Centre (GP)	43	18	20	5
Bristol City Council - Housing & Landlord Service	45	2	43	0
Avon and Somerset Constabulary	52	43	8	1
University Hospital Bristol and Weston NHS Trust	21	19	1	1
Bristol City Council – Support planning brokerage	2	0	2	0
Probation Service	177	68	109	0
Avon and Wiltshire Mental Health Partnership	40	12	26	2
Bristol City Council - Homeless Move on Team (Adult Social Care)	56	9	47	0
Bristol City Council - Access and Response team	3	1	2	0
Total Contacts by all agencies	**439**	**172**	**258**	**9**

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3.3. There were 439 contact episodes with or about Lily between 6th January 2020 and March 2021, a period of 14 months. Of these, there were 172 direct contacts with Lily which generated 258 contact episodes between agencies. Sometimes each contact episode involved multiple emails, telephone calls or face-to-face meetings. Where these refer to the same episode, they are counted as one contact episode. Consequently, the amount of activity generated by each contact with Lily is underestimated by these figures. They do, however, give some idea of the quantity of contact with Lily.

3.4. The agencies most frequently involved directly with Lily were the Probation Service (68 direct contacts) and Avon and Somerset Police (43 direct contacts). The Probation Service contacts were for overlapping, mainly public order offences. Police contacts were for multiple public order offences and these frequently led to contacts with mental health services. Rarely (twice) contact was initiated by Lily.

3.5. Contacts with housing services were for homelessness, threats of eviction and placements in hotels. Whilst housing services had fewer direct contacts with Lily than the probation service or the police, they had a total of 92 indirect contacts about Lily with other agencies.

3.6. Hospital contacts were for injuries sustained by Lily, some of which required further appointments. Nine of the 19 hospital direct contacts with Lily were on the day she died.

3.7. Lily contacted her general medical practice and was seen by GPs or practice nurses but there was oversight of these contacts by a named GP.

3.8. There was considerable time investment in, and service involvement with, Lily but this was did not prevent Lily from being street homeless when she died unexpectedly outside a hospital. Whilst Lily had been assessed to have eligible needs for care and support by Bristol City Council and a package of care had been commissioned for her, she was not in receipt of care services. Lily was reported to exhibit symptoms of mental health needs but she was not receiving mental health services. Whilst the services in contact with Lily communicated with each other, and the Creative Solutions Board flexed processes and eligibility to enable Lily to be housed temporarily, there does not appear to have been a consistent multi-agency plan to support Lily. Instead, service responses tended to be episodic and responsive to Lily's circumstances.

3.9. The contact with Lily between 1st January 2020 and March 2021 took place within the context of the response to the Coronavirus pandemic. The first "lock down", which placed restrictions on people, services and businesses began on 24th March 2020, and was fully lifted on 14th August 2020. However, restrictions began to be reintroduced on a tiered local level from 14th September 2020 and a second lockdown began from 5th November 2020. This remained in place until 2nd December 2020 when it was replaced with tiered local restrictions but the third national lockdown began on 6th January 2021. This began to be relaxed from 8th March 2021 and ended on 19th July 2021.

3.10. The national and local response to the pandemic impacted widely. Face-to-face contact decreased yet demand for services, sometimes to replace those that had been closed or limited by the 'lockdown', increased. Some services closed entirely. This included both universal and specialist services that might provide distractions for people who used drugs and alcohol and there was an increase in drug and alcohol related problems. There was also an increase in mental health need, which had been predicted at the time but in hindsight seems to have been even greater in younger people (Ford et al, 2021; Ashton et al, 2021).

3.11. Nationally, staff in health and social care were redeployed from specialist to more generalist work to support the Covid-19 effort and it is likely that there was an impact on the workload, ways of working, availability and accessibility of staff in Bristol. Staff were self-isolating, in accordance with government guidance, reducing the number of staff available to meet increasing demand. Bristol Royal Infirmary, like hospitals throughout the UK in response to Government requirements, limited the time spent in hospital by patients to reduce the risk of infection and to free capacity to treat people with Covid-19.

3.12. **SUMMARY CHRONOLOGY**

3.13. The following is a brief summary focused on key events in the period leading up to Lily's death. It is broken down into sections delineated by the nature of Lily's contact with services.

3.14. **6th January 2020 – 3rd August 2020**

3.15. During this period, Lily was in contact with her GP, the police, Avon and Wiltshire Mental Health Partnership and Bristol City Council Homeless Prevention and Housing and Landlord Services.

3.16. Lily lived in supported accommodation (a Level 1 (high) supported accommodation provider). Lily expressed delusions and paranoia and, according to Bristol City Council, behaved anti-socially, confrontationally and aggressively towards other residents and staff. Lily contacted the police to report offences against her (threats and a theft at the hostel and an assault in a pub), for which there was either insufficient evidence for, or Lily did not want the police to take further action. The police became concerned about Lily's mental health and that she required support with this and with housing. The police Lighthouse Safeguarding Unit (which supports victims of, and witnesses to, crimes) did not have a direct referral pathway into mental health services and their concerns were not shared with Lily's GP. Instead, Lily was signposted to her GP and mental health services.

3.17. On 5th March 2020, Lily attended Bristol Royal Infirmary with self-harm wounds to her abdomen but declined treatment and left. Lily attended her GP and was treated for self-harm injuries**.** A police officer contacted Avon and Wiltshire Mental Health Partnership since Lily had reported that she felt suicidal. The police officer was asked to encourage Lily to contact the Crisis Line. Further contacts with mental health services may have led to street triage if necessary but not to involvement with Lily.

3.18. The Level 1 (high) supported accommodation provider became increasingly concerned that it was unable to support Lily and sought support from Avon and Wiltshire Mental Health Partnership. Lily was arrested whilst intoxicated and making abusive comments towards members of the public and threatened to set fire to the hostel. Lily was deemed to lack mental capacity (she had used drugs) and was taken to Southmead hospital where she was detained in the s136 suite at Mason Ward operated by AWP. Lily returned home the next day.

3.19. The Level 1 (high) supported accommodation provider evicted Lily on 29th June 2020 for anti-social, confrontational and aggressive behaviour and for using verbally abusive language to both residents and staff. The police and an ambulance were called because of Lily's aggressive and abusive behaviour. The police tried to find somewhere for Lily to live and consulted with the Mental Health Crisis Team, who were unaware that Lily had been evicted. It is not clear where Lily went after this and it appears that, after she entered and caused a disturbance in student accommodation, she was left on the street. On 2nd July 2020, Lily presented as homeless at Temple Street and was placed in new accommodation. Lily did not get on well with fellow tenants and neighbours who made fifty complaints about Lily's behaviour towards them and to members of the public.

3.20. Consequently, Lily was evicted from emergency accommodation on 6th July 2020 and Bristol City Council ended its accommodation duty towards her.

3.21. Lily then came to the attention of the police again when she was arrested on 7th July 2020 for the public order offence of waving a chain around outside a supermarket and for harassing members of staff. Contact was made with Avon and Wiltshire Mental Health Partnership who assessed Lily whilst in custody. Lily refused to engage with the assessment. The assumption was that Lily had a probable drug induced mental disorder that had resolved.

3.22. Lily attended hospital on 9th July 2020 for a leg injury and was briefly admitted for observation but self-discharged the same day. On 11th July 2020, Lily attended hospital again but refused to leave. Lily was removed by hospital security. Later on 11th July, Lily returned to hospital and told another patient that she had bomb in a suitcase. The department was evacuated and Lily was arrested by the police. Avon and Wiltshire Mental Health Partnership assessed Lily again but could find no evidence that Lily's behaviours were driven by mental illness.

3.23. Lily was arrested again on 13th July 2020 for abusing a member of staff of a different supermarket. Avon and Wiltshire Mental Health Partnership could find no evidence of acute mental illness. Further public order incidents took place outside other shops and a petrol station.

3.24. On 29th July 2020, Lily assaulted a police officer, became abusive to a member of the public and was found in possession of drugs. Lily was arrested and released. On 31st July 2020, in an unrelated incident, Lily was arrested and charged for Outraging Public Decency. Lily received a community order with a rehabilitation activity requirement.

3.25. **4th August 2020 – 16th December 2020**

3.26. During this period of time, Lily was in significant contact with the probation service. Lily attended her first probation appointment for a new community order on 4th August 2020. According to the probation service, Lily appeared delusional, said that she had been sexually abused by a woman in the past and would only work with men or she would self-harm. There is no record that this allegation of historic sexual abuse was explored further or that a further referral was discussed with Lily or made on her behalf, for mental health support with past trauma. Lily wanted support to find somewhere to live. Contact between Lily and the probation service continued almost daily about finding accommodation and further public order offences.

3.27. On 11th August 2020, Lily attended a probation appointment with a new intimate partner, with whom she was now living. According to the probation service Lily continued to express delusional thoughts. It became apparent by 17th August 2020 during contact between the Probation Service and Bristol City Council that Lily's new partner was an adult at risk of abuse and concerns emerged that Lily might be financially abusing him. Domestic abuse and safeguarding processes began and there was a concern that Lily might be coercing and controlling her partner.

3.28. In September 2020, Lily's probation officer, who was in training, began to receive psychology support to manage Lily. By 15th September 2020, Lily became homeless again since the domestic abuse and safeguarding interventions had led to the end of her relationship with her partner in order to protect him. Lily threatened to kill herself, but the probation service considered this to be Lily's attempt to gain support since Lily had made similar threats in the past. Work to obtain an injunction to prevent contact by Lily with her ex-partner was begun.

3.29. On 18th September 2020, the probation service noted that Lily's behaviour had deteriorated since she had become street homeless and her relationship with her boyfriend had ended.

3.30. On 20th September 2020, the police were called when Lily walked into a hotel asking for an ambulance and had become aggressive. No further action was taken and Avon and Wiltshire Mental Health Partnership concluded that there was little they could do since Lily's behaviours did not indicate mental health needs. It does not appear that any history or pattern of previous concerns or referrals was considered. Instead, each referral to mental health services was considered in isolation.

3.31. Lily attended the probation office on the morning of 22nd September 2020, where she slept under a chair for seven hours. The probation service tried to support Lily to find somewhere to live and liaised with support agencies. Possible placements for Lily refused to accommodate her due to her history. On 2nd October 2020, Lily was placed in a hotel with support provided. On 9th October 2020, the hotel notified Bristol City Council Housing and Landlord Service that it wanted to evict Lily due to her anti-social behaviour. Lily explained to her probation officer that there were a lot of people who used drugs and alcohol there, with whom she had arguments. Lily's probation officer discussed future housing plans for Lily with Bristol City Council Housing and Landlord

Service. Lily was in the hotel temporarily until a decision about her priority for housing could be made. On 28th October 2020, the Probation service noted Lily's vulnerabilities whilst living at the hotel and the risks she posed to, and faced from, other people staying there.

3.32. The Golden Key service became involved with Lily at the end of October 2020 and negotiated with the hotel on behalf of Lily to remain there rather than be evicted. On 10th November 2020, Lily, however, found private rented nightly accommodation and was evicted from the hotel. Lily was then placed in Bed and Breakfast accommodation by her recently allocated social worker, who tried to find more permanent accommodation for her and to complete a Care Act 2014 assessment of Lily's needs. On 17th November 2020, Lily was allocated a Housing Advisor from the Bristol City Council Homeless Move on Team and was placed on the Homeless Pathway.

3.33. On 26th November 2020, Lily breached the injunction, but the police had no powers of arrest and on 27th November 2020, the Care Act assessment was completed and the decision not to house Lily was overturned. Information about Lily was prepared for submission to the Bristol Creative Solutions Board. Lily complained about the inappropriate behaviour of her landlord's son towards her. When this was investigated, Lily denied the allegations she had made and wanted to remain in the accommodation. Despite this, enquiries into the incident continued.

3.34. **17th December 2020 – 17th February 2021**

3.35. On 17th December, Lily's case was presented to the Bristol Creative Solutions Meeting and following a meeting between Bristol City Council, the Probation Service and Golden Key on 21st December 2020, Lily moved into a hotel. Lily then stayed in a series of short-term hotel placements shown in table 2. Lily's stay at each hotel was arranged at weekly intervals

Table 2: Lily's hotel accommodation and moves between 22nd December 2020 and 25th February 2021

Hotel	Dates	Notes
Hotel 1	22nd December 2020 – 4th January 2021.	
Hotel 2	4th January 2021 to 11th February 2021.	On 2nd February 2021, Bristol City Council Homeless Move on Team notified Bristol City Council Brokerage that Lily required seven hours of support per week.
Homeless Hostel	11th Feb to 16th February 2021	Evicted on 12th February due to her behaviour, Lily went to a hostel for homeless people provided by St Mungo's
Hotel 3	16th February to 25th February 2021	Lily was placed out of area
It is not known where Lily lived.	25th February 2021 until 4th March 2021.	Lily was banned from the Hotel chain

3.36. A similar pattern of regular meetings with and support from the Probation Service continued. There was limited contact with the police. On 10th February 2021, the police attended the hotel where Lily was living following reports that she was going to hurt herself. Lily appeared erratic and to be responding to voices. Lily was detained under s136 Mental Health Act 1983, following advice from the mental health triage team, and was taken to Mason Ward, operated by AWP at Southmead Hospital. Lily did not meet the criteria for admission. It does not appear that previous concerns about, and contacts with, Lily informed the AWP decision. Efforts were made to find new accommodation for Lily and to refer her for mental health support, but on 24th February 2021, the Bristol ACE mental health team told Lily's social worker that this was contingent upon where Lily lived. The ACE service was unable to work with Lily if she received housing with support.

3.37. **Events in March 2021.**

3.38. Lily moved to a hotel that was part of a different chain between 4th March and 11th March 2021. On 5th March 2021, the Bristol City Council Housing & Landlord Service was unable to place Lily further and was ending its main housing duty towards someone who was homeless. Lily was admitted to Mason Ward, operated by AWP at Southmead hospital, under s136 on 5th March 2021 but discharged on 6th March 2021. Lily was judged to be "feigning" mental illness in order to access services. Lily became street homeless.

3.39. On 6th March 2021 Lily was brought to Bristol Royal Infirmary Emergency Department by ambulance, hypothermic with a low heart rate, intoxicated, verbally aggressive and declining interventions. Lily was medically stabilised and assessed as safe for discharge.

3.40. On 7th March 2021, Lily attended Bristol Royal Infirmary Emergency Department. Lily was threatening and refused to leave the hospital grounds. Lily approached Bristol City Council and the Probation Service for temporary accommodation and on 10th March 2021 said that she had found accommodation at Alpha House, Coronation Road.

3.41. A few days later at 7.30am in March 2021, Lily was found on a bench outside another hotel. Lily had been there since 3am, shouting at passers by, acting strangely and banging on the doors. The hotel staff called the police. Lily was found soaked through and not responsive and was taken by ambulance to Bristol Royal Infirmary and treated for hypothermia. Lily was discharged at approximately 14.30pm that day and excluded for eight hours due to her behaviour.

3.42. However, Lily did not leave the hospital area. Members of hospital staff who knew Lily well continued to offer her assistance. Lily was discovered outside the hospital grounds in the early hours of the morning in cardiac arrest, by a passing member of staff. Though efforts were made to resuscitate her, these were unsuccessful. Lily died in hospital later that day.

4. ANALYSIS

4.1. How organisations responded to Lily and understood her needs

4.2. Lily appears to have been self-neglecting. This was recognised for example on 15th January 2020 by Bristol City Council Homelessness Prevention. Self-neglect can be defined as, "*the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecter and perhaps even to their community*" (Gibbons et al, 2006, p.16). Self-neglect is one of the ten categories of abuse and neglect specified in the adult safeguarding sections of the Care Act statutory guidance. Despite this, only one adult safeguarding concern was raised about Lily. This was in response to a complaint that Lily had made about the behaviour towards her of her landlord's son. Otherwise, it appears that Lily was not considered to be experiencing abuse or neglect.

4.3. There is extensive research into, and guidance on, working with people who self-neglect. For the purposes of this SAR, it is sufficient to focus only on a summary of this guidance. Readers keen to explore the research basis for this guidance will find several of the publications listed in the bibliography to be of value.

4.4. The guidance is that practice with people who self-neglect is more effective where practitioners:

- Seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience.
- Work patiently at the pace of the individual, but know when to make the most of moments of motivation to secure changes.
- Keep constantly in view the question of the individual's mental capacity to make self-care decisions.
- Communicate about risks and options with honesty and openness, particularly where coercive action is a possibility.
- Ensure that options for intervention are rooted in a sound understanding of legal powers and duties.
- Think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks.
- Work proactively to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals.

4.5. In order to do this, the following approaches should be used:

- History taking. Explore and ask questions about how and when self-neglect started.
- Be proactive and identify and address repeated patterns of behaviour.
- Try different approaches, use advocates (of all kinds, including friends, formal advocates for particular functions including Care Act advocates and community, citizen and peer advocates) and concerned others, raise concerns, discuss risks, maintain contact, avoid case closure.
- Ongoing assessment and review of mental capacity.

4.6. There was little history taking. The Probation Service recognised that Lily's background featured considerable trauma but in the majority Lily's contacts with other services this does not appear to have been recognised or used to shape interventions.

4.7. There also does not appear to have any identification of patterns in Lily's contact with services or an escalation in, for example, the severity and frequency of incidents. This was hampered by a lack of safeguarding concerns. The adult safeguarding process can be an opportunity to bring organisations together to share information, develop a mutual understanding of concerns and patterns and to plan interventions. Consequently, there was little evidence of different approaches being tried. Avon and Somerset Constabulary intervened in response to incidents and the Probation Service was the only consistent support in Lily's life. Housing services tried to accommodate Lily and arranged consecutive short stays in different hotels between 22nd December 2020 and 11th March 2021 for Lily.

4.8. Except for presentation to the Creative Solutions Board on 15th December 2020, which included discussion of Lily's funding for housing, a peer mentor to work alongside probation, psychological input and therapeutic/practical support, there was little joint working. Due to Lily's continued housing instability and homelessness these interventions were not put in place before Lily died.

4.9. **Repeated hospital admissions and contact with services.**

4.10. Lily attended the University Hospital Bristol and Weston NHS Trust seven times between 5th March 2020 and 11th July 2020. In response, on 13th July 2020, a support plan for Lily was created by the High Impact User Team. This plan included that if Lily attended hospital, in addition to being treated clinically, safeguarding concerns would be considered and Lily's living arrangements would be explored and a homelessness referral made if needed.

4.11. Additionally, If Lily was admitted late at night, then consideration would be given to an overnight stay on an observation unit with a homelessness referral made in the morning. Lily would also be encouraged to visit her GP. An intervention by the mental health liaison team would also be considered. This was a comprehensive and seemingly appropriate plan but does not appear to have put into action when Lily attended University Hospital Bristol and Weston NHS Trust in March 2021.

4.12. On 6th March 2021, Lily was brought by ambulance cold and with a low heartrate. She was intoxicated and declined help. Lily became physically aggressive and self-harmed. The police were called and Lily was discharged at 9.49pm. None of the actions planned on 13th July 2020 were carried out.

4.13. Lily was brought back to hospital again a few days later in March 2021 following an accidental overdose. Lily was intoxicated, had self-harmed and was cold and wet. Lily became aggressive and declined observations and interventions. Lily was discharged and excluded from the hospital at approximately 14.30pm. Lily remained on or near the hospital premises and was found in cardiac arrest in the early hours of the morning. According to University Hospital Bristol and Weston NHS Trust, patients who have been excluded from one hospital will be diverted to another hospital, such as Southmead Hospital.

4.14. These were opportunities for the plan formulated with the High Impact User Team to have been implemented. It appears, however, that the plan had not considered how

Lily's aggressive behaviour and the difficulties in gaining her compliance and willingness to engage would be approached and managed. The hospital was also responding to the Coronavirus pandemic, like all hospitals, by limiting lengths of attendance to reduce infection risk and to treat patients with Covid-19. Hospitals were also under intense staffing pressures. Despite the plan, Lily was excluded briefly from the hospital, rather than admitted, due to her behaviour. It appears that the High Impact User Team plan, created to respond to the challenges that Lily presented to services, was not implemented because of challenges in capacity resulting from the response to, and effects of, the Covid-19 pandemic.

4.15. Lily had a complex range of needs. These included criminal and anti-social behaviour, mental health difficulties, substance use, self-neglect and homelessness.

4.16. Previous Safeguarding Adults Reviews (for example, Andrew, Staffordshire and Stoke 2022, Brian, Swindon, 2022; Ben Croydon, 2023) building on previous meta-analyses of SARs, have identified eleven characteristics that frequently appear in reviews featuring people who self-neglect. These are:

- Non-engagement with services
- Self-neglect
- Exploitation of a vulnerable person
- Domestic and child abuse
- Chronic health problems
- Mental health conditions
- Lack of family involvement
- Traumatic events triggering substance use
- High levels of alcohol/ substance intake and over-reliance on substance use to explain the adult's presentation
- Regular contact with ambulance services and attendance or admission to hospital
- Unpopularity with the local community or concerned neighbours

4.17. The presence of these characteristics are indicative of poor outcomes unless different approaches are taken. They are also predictive in that if some characteristics are present then it is likely that others will also be found.

4.18. It would appear that Lily presented with most, if not all, of all of these characteristics. Services struggled to engage with Lily, who self-neglected, had complained that she had been assaulted and appears to have exploited her partner. Lily was believed to have, and said she had, experienced trauma and abuse and did not have involvement with her family. Lily used substances, which were considered to explain her presentation to mental health services. Lily had attended hospital regularly and frequently complained about by people she lived with. The only characteristics that are not clearly present were the presence of mental health conditions, although these were suspected by the majority of services Lily was in contact with, and long-term health conditions. Lily, however, was 30 years old and so may have been younger than the cohort in the previous reviews and also may not have been diagnosed due to non-attendance. It is also unclear, but very possible, that Lily's substance use was triggered by traumatic events and used as a coping mechanism. With the exception of Lily's

Probation Officer, it does not appear that there was awareness, or curiosity to suspect, that Lily was likely to have experienced trauma in her past.

4.19. Consequently, Lily's needs appear to have been understood in isolation from each other and not to have been linked together and recognised as a pattern. Lily needed somewhere to live, she had assessed care and support needs and needed support to stop reoffending. Lily also possibly needed support with her mental health and substance use. Whilst services tried to meet Lily's housing, offending and care and support needs, no overall understanding of these was turned into a coordinated intervention informed by evidence from previous SARs and from practice guidance.

4.20. **How was Lily's mental capacity and mental health understood?**

4.21. All the contacts with Lily took place within a policy context that emphasises choice, independence and personal control and which forms part of an overall neo-liberal Government led approach to adult social care and welfare (Ward et al, 2020).

4.22. Safeguarding Adults Reviews (amongst others Adults B and C, South Tyneside; Mr I, West Berkshire and W, Isle of Wight; Andrew, Staffordshire and Stoke) have increasingly focused on the challenges of practicing in a way which balances the principles of freedom of choice and self-determination with the duties, public expectations and moral imperatives of public services. These take place within a legislative context that includes the Human Rights Act 1998[1], the Care Act 2014[2], the Mental Capacity Act[3] and the Mental Health Act 1983.

4.23. At the intersection of all these factors is the question of the extent to which adults should be left by public services to behave in a way that is objectively detrimental to their health and wellbeing or which threatens their lives. More fundamentally, this is a question of prioritising freedom of choice or prioritising protection from harm. The guidance on working with people who self-neglect helpfully challenges the binary nature of these questions by asking practitioners to consider:

4.24. Is a person who self neglects really autonomous when:

a) They do not see how things could be different.
b) They do not think they are worth anything different.
c) They did not choose to live this way, but adapted gradually to circumstances
d) Their mental ill-health makes self-motivation difficult.
e) They have impairment of executive brain function.

4.25. Is a person who self neglects really protected when:

a) Imposed solutions do not recognise the way they make sense of their behaviour.
b) Their 'sense of self' is removed along with the risks.
c) They have no control and no ownership.
d) Their safety comes at the cost of making them miserable.

4.26. The extent to which a person who self neglects can put whatever decisions they make into effect should also be considered. Whilst the Mental Capacity Act does not

explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice.

4.27. Lily's mental capacity was considered once, when Lily was found to lack mental capacity (to make which decision is not recorded). Lily was frequently concluded to have the mental capacity to make (frequently unspecified) decisions, but to make unwise decisions. There does not appear to have been consideration of the impact of trauma, drug and alcohol use on Lily's mental capacity or of involving the Court of Protection in determining whether Lily's decisions were unwise or indicated a lack of mental capacity.

4.28. Agencies found Lily very difficult to work with. Lily often cancelled appointments, changed her mind and behaved aggressively and avoidantly. There was a recognition that at least some of Lily's behaviours were trauma reactions and housing and homelessness services and the Probation service tried to maintain contact with Lily to provide support to her.

4.29. Despite this, Lily's mental health or substance use needs do not appear to have been fully explored. There was episodic contact with mental health services at times of crisis which did not find that Lily had diagnosable mental health needs. Lily was later believed to be "feigning" mental health difficulties in order to access support. The reasons for this belief are not explained in the information provided for this review. It is assumed that the mental health assessments were conducted thoroughly but the lack of identification of mental health needs appears to be somewhat at odds with the reports of Lily exhibiting delusional thinking and at times hallucinating, which might also have been exacerbated by substance use. There may be a development area here to explore how mental health assessments might be made over longer periods of contact rather than just during crisis attendances at s136 suites. There may have been a missed opportunity to refer on to community based mental health services for this longitudinal assessment but this would have required Lily's consent and cooperation and finding effective ways to engage with her. There was no referral to, or attempt to engage Lily with, substance use services.

4.30. **How was Lily's homelessness understood?**

4.31. It appears that Lily's homelessness was often understood to be a consequence of her behaviours. The Probation Service, however, identified when Lily's housing was not appropriate and noted the impact of Lily's frequent changes of address, which were often at short notice. Bristol City Housing made considerable efforts to rehouse Lily in a variety of short-term placements, some of which provided onsite support. Lily and her fellow tenants seem to have found it difficult to live to together and Lily presented challenges to support staff.

4.32. **Were there any barriers to practice, including for example, eligibility criteria, discharge criteria, conscious or unconscious biases in judgements about lifestyle choice, personal responsibility etc, recognition and response to self-neglect and mental health needs, etc. and Did inequalities impact on access to, and the response by, services to Lily?**

4.33. Practitioners involved in this review identified the following factors in the service responses to Lily.

4.34. **The impact of trauma can shape a person's behaviour.**

4.35. There is considerable evidence of a significant causal relationship between the experience of trauma and difficulties in engagement in services. This also increases vulnerability.

4.36. Practitioners considered that it was very hard to establish what Lily had lived through, but there was awareness of trauma, physical and emotional abuse, exploitation and isolation in her life. Lily had extensive contact with the criminal justice system and had served frequent prison sentences. She also had periods of homelessness and housing instability. Consequently, Lily experienced multiple exclusion homelessness.

4.37. There was an understanding that Lily's behaviour was in response to this background of trauma and could be considered to be a means of survival, even if it perpetuated her problems and was maladaptive in interactions with services.

4.38. Lily's offending behaviour could be understood as an example of her needs. Lily was very vulnerable and open to exploitation.

4.39. **Personal characteristics can affect service responses.**

4.40. The delivery of human services involves interactions between people who use services and the people who provide them. This can mean that the quality and effectiveness of service delivery can be affected by the nature of the relationships formed. In turn, this can be influenced by a number of interpersonal factors. Examples identified include:

4.41. Lily was liked by some of people that she encountered but sometimes she would appear very tough, abusive and difficult to like. This could affect attitudes and approaches to Lily since it can be hard to feel sympathy and empathy for someone who behaves abusively.

4.42. Responses to Lily varied at an individual practitioner level. Skills sets, roles and time available are very varied. People who have experienced trauma, however, need consistency.

4.43. Beliefs about lifestyle choice and victim blaming influence service responses. Consequently, lack of engagement with services is located in the client.

4.44. Golden Key/ Arnos Vale use a trauma informed approach and understood and recognised how to intervene.

4.45. There were no safeguarding concerns about Lily because she did not give permission for them to be raised. On reflection, practitioners considered that there was an element of victim blame in this. Lily's mental capacity, lifestyle and criminal

behaviours prevented safeguarding work because of perceptions about her. Sometimes practitioners use concerns about a "High Risk of Death" to draw attention to someone they are worried about but this does not always lead to a change in service~~s~~ responses.

4.46. **Trauma informed service responses are therefore essential.**

4.47. There is also considerable evidence that trauma-informed approaches to service delivery, which understand, predict and intervene in, for example, difficulties in engagement and aggression, rejection, recurring patterns of behaviour and dependency.

4.48. Practitioners considered that Lily exemplified people from marginalised groups who do not fit in with the way services operate. Lily did not behave in the way that services expect her to. There were also questions of whether Lily, and people like her, have needs for care and support.

4.49. Lily would not (or could not) attend appointments at the allotted times. Lily required outreach follow up rather than to be expected to always come to services.

4.50. Probation, police and acute hospital are involuntary services and cannot refuse to work with people. Consequently, they tend to be the most involved with people like Lily. They are, however, often not best equipped for this. For example, whilst the police have a dedicated mental health link officer in the control room who supports police officers attending someone with mental health needs, custody suites are not suitable for people with mental health needs.

4.51. **Service capacity and skill influences the effectiveness of interventions.**

4.52. Responses to Lily were influenced by the availability of services and their ability to work with her. Examples identified by practitioners included:

4.53. Mason Ward at Southmead hospital has limited (four beds) for mental health crisis so the police take people to Devizes in Wiltshire. This a s136 suite for assessment. It is for 24-hours. However, it takes a long time for someone to be properly assessed and treated and requires that ways are found to engage with them. It would appear that developing a trusting relationship with Lily was necessary in order to work with her and to do this would require multiple successful contacts with her. The infrastructure needs to be improved i.e. safe houses, user led services etc. The Sanctuary will not take people who are violent or who use substances.

4.54. Street triage can be very helpful for the police. Subject to the availability of funding, a mental health car/ambulance will be introduced to support the police and transport people to a place of safety in an ambulance.

4.55. Lily's Probation Officer tried to have focused conversations with Lily on the causes and consequences of her behaviours. The Probation Service has to meet a range of needs. Other Probation officers would not work with Lily anymore. Lily's Probation officer was a trainee at the time and had a limited caseload so had more time for Lily. He had

also worked with people with mental health needs before. Not all Probation Officers have this experience.

4.56. The emergency department environment is very busy and it can be difficult to support someone like Lily. There is the Homeless Support Team; Drug Specialist Team; Alcohol Specialist Team and High Impact Users Team as well as safeguarding team. All, however, operate between 9am and 5pm Monday to Friday. Practitioners considered that they were under resourced compared to demand. They relied on internal referral within the hospital. Lily was likely to be known to these teams and had a personal support plan in liaison with High Impact Users Team.

4.57. Avon and Wiltshire Constabulary has a safeguarding team, but this usually deals with referrals to other organisations. A lot of unofficial safeguarding work is done by Community Police Teams.

4.58. **Joint working and communication is essential but there is room for improvement**

4.59. Effective work with Lily and people like her requires coordinated multi-agency interventions.

4.60. Practitioners identified that the guidance for working with people with a dual diagnosis of mental health needs and substance use needs is that there is “no wrong” door for accessing support. Despite this, people do ”bounce” between services. There needs to be a way to reach out to people where they are and when they are ready.

4.61. The interface between alcohol and mental health needs requires further development. There is, for example, a divide between commissioning: substance use services are local authority/ public health commissioned but mental health services are commissioned by the Integrated Care Board.

4.62. The police do not have direct access to mental health services, apart from mental health street triage.

4.63. There is a need for increased information sharing between the police and mental health wards. Police officers are not trained in mental health needs and are there for the person’s safety. It is hard for the police to describe someone’s behaviour. Sharing by the police of body-camera footage might assist with this, although this may present challenges in terms of data protection regulations and consent.

4.64. There is a lack of understanding amongst other agencies of the role of the Probation Service, which for Lily, was the most consistent service in her life and provided a level of mental health support to her.

4.65. **The Importance of housing stability**

4.66. Stable accommodation is often considered “foundational” for the success of other forms of support or intervention. Practitioners considered that housing should be a gateway for access to other services.

4.67. Homelessness is a Catch-22 situation: people require housing to receive support, but require support to obtain housing. They need to be considered together.

4.68. Practitioners identified that temporary accommodation is not a good environment for people like Lily due to instability and risks arising from interactions with other people sharing the same accommodation.

4.69. The interface between the Probation Service and housing needs to be improved since it is not always effective as evidenced by the struggle to access accommodation for Lily.

4.70. **Mental capacity is not always understood.**

4.71. Trauma and substance use can impact upon mental capacity, typified by an inability to turn decisions into action and decisions influenced by substance dependency. Practitioners considered that Lily's mental capacity was not well understood. The challenges of understanding and assessing and responding to mental capacity include:

4.72. Police investigations do not always proceed for people with mental health needs, whom it is assumed do not have mental capacity to support prosecution. Police investigations can, however, proceed in the public interest.

4.73. Assessing mental capacity in hospital settings is a very grey area and practitioners feel that more guidance is required.

4.74. It is harder to demonstrate lack of capacity than it is to assume that a person has mental capacity. This can lead to lack of consideration of mental capacity.

4.75. **Were there examples of good practice and facilitation of good practice?**

4.76. There were several examples of good practice. The Probation Service, and especially Lily's Probation Officer, showed considerable dedication to Lily and flexibility in finding ways to support her. The Probation Service provided psychological support and advice to Lily's Probation Officer, also advocated for Lily to receive services. The Police also tried to support Lily to access mental health services and took a flexible and solutions focused approach when in contact with her.

4.77. Bristol City Council Housing services also persisted in finding accommodation for Lily, negotiated on her behalf and showed restraint in ending its housing duty. The Golden Key organisation also tried to support Lily to maintain her tenancies. Bristol City Council allocated a social worker to Lily, who assessed her needs and a package of care was commissioned for her. Lily's housing instability, however, appears to have prevented this from being provided.

4.78. Practitioners identified that changes have been made following Lily's death. At the time of her death, Lily was outside of the hospital boundaries. After Lily's death a change has been made so that when someone is booked into the Emergency Department, there is an alert if they have a Personal Support Plan (which Lily had).

Clinicians have to note that they have acknowledged the Personal Support Plan and any reasons for variation from it.

4.79. Where there are doubts about mental capacity when a person wants to self-discharge then capacity is considered as part of the discharge process. There is also a standard operating procedure now. This includes the security staff as well as clinical staff. There is now a process to guide staff on what to do. i.e. contact clinical site team if the person who has been discharged is still visible.

4.80. **How effectively did organisations communicate, share and use information and work together?**

4.81. The services involved with Lily were in frequent contact about her and information was regularly exchanged. Effective practice requires the following support:

- Agencies share definitions and understandings of self-neglect.
- Interagency coordination and shared risk-management is facilitated by clear referral routes, communication and decision-making systems.
- Longer-term supportive, relationship-based involvement is accepted as a pattern of work.
- Training and supervision challenge and support practitioners to engage with the ethical challenges, legal options, skills and emotions involved in self-neglect practice.

4.82. There does not appear to have been a shared understanding that Lily was self-neglecting and this did not lead to a coordinated multi-agency approach. Consequently, no safeguarding concerns were raised about Lily as an adult at risk, although they were raised about her as an adult alleged to have caused harm to her partner.

4.83. The Probation Service took a long-term approach to Lily but this was to an extent determined by its function. Other services had largely episodic contact with Lily initiated by crisis. Mental Health services did not engage with Lily since her presentation of mental health needs was determined to be the result of substance use.

4.84. The Probation Service provided psychological support to Lily's Probation Officer but it does not appear that any other organisations supported their practitioners in this way. There does not appear to have been consideration of other legal options, such as resort to the Court of Protection about Lily's mental capacity, beyond those available to the police or to housing.

4.85. Information shared about Lily with Lily's GP practice did not specify if the GP was being requested to take action.

5. CONCLUSIONS

5.1. **What lessons can we learn and how can we turn these into recommendations for change including how to embed system change based on system flex?**

5.2. The lessons can be summarised as follows.

5.3. **Housing stability is foundational for the success of other interventions.**

5.4. Considerable effort was made to find Lily temporary accommodation, often in hostels or hotels. Lily faced risks from, and posed risks to, other occupants in these types of accommodation. Whilst this approach significantly reduced the number of times when Lily would otherwise have been street homeless, it did not provide Lily with the housing stability and it is likely that she required. No housing providers were able to accommodate Lily for long due to risks she posed to herself and to others. She had been evicted from the highest level of general supported accommodation for homeless people. It is likely that Lily required specialist housing, which included mental health or other forms of support.

5.5. According to the United Nations Committee on Economic, Social and Cultural Rights, satisfactory housing consists of: legal security of tenure; availability of accessible services, facilities and infrastructure; habitability; accessibility (e.g. access to employment, health services, schools, etc); cultural adequacy; and affordability. There is a strong interrelationship between mental health and homelessness including insecure housing, such that housing can be considered to be "foundational" to good mental health and wellbeing. Secure, stable and safe housing is necessary for other interventions, such as mental health, substance use or social care support to be effective.

5.6. There is a shortage of affordable housing and housing options are limited. It is likely to be unrealistic to expect that single person secure accommodation was available for Lily. However, an approach that combined and coordinated housing with support, rehabilitation and occupation might have been effective. Lily had been assessed, for example, by Bristol City Council to require seven hours of social care support each week but Lily was in short term, frequently changing, accommodation which made this support difficult to deliver.

5.7. **A comprehensive multi-agency, multi-disciplinary approach is most effective. Good work by some agencies is unlikely to be enough without the involvement of all the relevant organisations.**

5.8. Very considerable effort was made by the Probation Service, the Police, Bristol City Council Housing services, Golden Key and, to a lesser extent by Bristol City Council Adult Social Care, to engage with Lily and to persist with trying to support her. Temporary accommodation was regularly found for Lily, even when housing duties had been exhausted, Lily's Probation Officer provided consistency and went beyond criminal justice involvement with Lily to support her to travel and find somewhere to live. The Probation Service provided Lily's Probation Officer with psychological support and advice to manage Lily and the relationship with her. The Police tried to obtain support for Lily and facilitated her access to mental health services by taking her to hospital but lacked direct access to Lily's GP and mental health services.

5.9. There was, however, little mental health service involvement. Mental health needs were a regular feature of Lily's contact with other services which referred Lily to specialist mental health services. Lily was, however, assessed not to have mental health needs and Lily's presentation was concluded to be the result of substance use. This review cannot make judgements on the accuracy of this conclusion.

5.10. There was, however, no involvement with Lily by substance use services during the time covered by this review. Specialist substance use input might have provided further options to support Lily including substance use detoxification and rehabilitation.

5.11. The evidence from other SARs shows, however, that people with both substance use and mental health needs face a "Catch-22" situation in which substance use services are unable to make assessments until mental health needs are met whilst mental health services cannot make assessments until substance use needs are met. It may be helpful to clarify if this situation exists in Bristol.

5.12. **Comprehensive multi-agency, multi-disciplinary approaches require coordination.**

5.13. Evidence from other SARs has frequently identified the need to coordinate multi-agency approaches in some way. This might be done through specialist forums such as Multi-Agency Risk Management meetings or High Risk panels but the adult safeguarding process can also be used to coordinate involvement and action.

5.14. Lily's self-neglect, however, did not lead to safeguarding interventions. Safeguarding enquiries were made when Lily was identified as a Person Alleged to have Caused Harm and also when she made an allegation about the behaviour of her landlord's son towards her. Good practice was shown in this since the enquiry continued despite Lily's subsequent retraction of the allegations she had made.

5.15. There does not appear to have been a recognition that Lily was self-neglecting, although she was understood to be at risk of homelessness, abuse, exploitation and also to pose a risk to others. Self-neglect is one of the categories of abuse or neglect included in the Care and Support Statutory Guidance to the Care Act 2014. An enquiry under s42 Care Act 2014 may have provided a means of bringing together all the agencies involved with Lily to share information about the challenges they faced, the approaches they had taken and the outcomes they had achieved. This could have assisted in identifying other organisations to involve and to make referrals to and to coordinate approaches.

5.16. There was no mention of any of Lily's family members or friends in any of the records available for this SAR. The AMHP report states that Lily had said that she had been locked out of her family home when she was 16 years old. Therefore, it would seem that Lily may have been estranged from her family.

5.17. Family members can be useful partners when working with someone who self-neglects and with who agencies find it hard to engage. This does not always require consent (see Appendix 1)

5.18. **Trauma informed approaches that build on a person's strength may offer greater opportunity for engagement.**

5.19. More coordinated multi-agency information sharing and joint working may also have prompted trauma informed interventions. Such interventions could have understood that the challenges Lily presented to services were predictable consequences of life trauma and that therapeutic interventions might be possible to support her.

5.20. Lily was also without any form of occupation, even though she was of working age. There is evidence from other SARs and from practice guidance and experience of the positive benefits of paid work or of activities that are meaningful to and use a person's strengths and interests. Approaches that focused on identifying what Lily liked and was motivated to do, might have provided an opportunity to engage with her and also to have provided some structure to her life.

5.21. Services struggled to find ways to engage with Lily and in these situations, perceptions of a person's agency and responsibility can influence practice. Safeguarding Adults Reviews, analyses and practice guidance have identified several practitioner perceptions that affected the way that services responded to people who self-neglect and with whom services struggle to engage:

- Behaviours were seen as personal choice
- The extent of substance use was underestimated
- Lack of service capacity
- High thresholds for support and for safeguarding concerns
- Understanding of the Mental Capacity Act and legal literacy

5.22. Some of these factors were present in with work with Lily. Services tried to manage Lily's behaviours and not to hold her wholly responsible for them but did not fully use a trauma-informed approach. Whilst Lily appears to have been liked, there is a risk that repetitive problems reduce compassion and induce weariness and low expectations and hope for change in practitioner. The concept of "malignant alienation" can be used to understand the problems that practitioners face. The phrase "malignant alienation" was coined by Morgan (1979) to describe the process by which empathy and sympathy are lost and members of staff tend to construe the behaviours of a person who uses services as provocative and unreasonable (Watts and Morgan, 1994). This process is termed malignant since it grows and is associated with fatal outcomes.

5.23. Malignant alienation was first identified in services which support people with personality disorders who self-harm or attempt suicide. The concept also applies to other situations too (Hadfield et al, 2009). General methods for resisting the development of malignant alienation include recognising it and that the difficulties are mutual rather than located in the person receiving services; exploring the reasons for, and functions of, the behaviours; recognising that these are shared problems not misbehaviours; assessing for treatable mental health conditions including depression; and using boundaried engagement approaches which moderate expectations, acknowledge limitations and establish rules of behaviour (see for example, https://cdn.mdedge.com/files/s3fs-public/Document/September-

2017/0807CP_Cases.pdf). It would appear that an active approach to mitigate against malignant alienation is more effective than a passive one. The psychological support provided within the Probation Service to Lily's Probation Officer was a notable example of these methods being used.

5.24. One of the persistent lessons from Safeguarding Adults Reviews, research and practice guidance is that difficulties with engagement, resistance and service refusal are components of self-neglect. Consequently, they should be expected, planned for and addressed. They should not be considered separately from self-neglect and should not lead to, for example, discharge for lack of adherence to treatment, failure to attend appointments or the rejection of service offers.

5.25. There is a need to consider how to support agencies and staff to manage relationships with people who are hard to engage, to build up trust and to meet their complex needs. This will involve developing skills across the provider and commissioning workforce to recognise and respond to the challenges of service refusal and of unacceptable behaviour. This requires the ability to distinguish self-neglect from other forms of refusal, the resilience to depersonalise aggressive outbursts and insults and the skill to recognise them as indications of the need for services. This must be supported by management supervision and the formulation and testing of behaviour management strategies.

5.26. **Mental capacity should be questioned when someone is self-neglecting and services are struggling to engage with them.**

5.27. There was little consideration of the extent to which Lily's behaviours and challenges with engagement with services were affected by her ability to understand, retain, use or weigh information relevant to the decisions involved, although Lily appears at times to have been able to communicate her decisions. Lily's mental capacity had been assessed once by Avon and Somerset Police. On this occasion, Lily had been found to lack mental capacity (to make which decision is not recorded) and she was taken to Mason Ward at Southmead hospital, where she was then detained under s136 Mental Health Act.

5.28. Further attention to Lily's mental capacity might have meant that opportunities to assess her mental capacity could have been taken when for example, Lily wanted to retract allegations she had made and seemed to be making decisions that would lead her to harm.

6. SUGGESTION FOR FURTHER DEVELOPMENT

6.1. The purpose of this Safeguarding Adults Review was to prompt a number of work streams to implement learning. The following are suggestions for further development based on feedback from the practitioners involved in this review.

6.2. **Support for staff.**

6.3. There is a need to develop competence, aptitude and skills in joint working and managing people who services find it difficult to engage with. This can include using trauma informed practice and establishing boundaries of engagement. It could also include identifying and responding to "malignant alienation" and creating a shared environment which fosters and supports these approaches. A staff support network may also be useful to prompt peer support.

6.4. **Recommendation**: The KBSP to review how effectively trauma informed practice (including support systems for staff) is embedded (for example, in procedures, protocols, staff support networks) and use the results of this to identify training needs and process ~~and~~ procedure changes.

6.5. **Mental Capacity.**

6.6. The first principles of the Mental Capacity Act are that *a person must be assumed to have capacity unless it is established that they lacks capacity* and that *a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success*. It is therefore essential to support, and to clearly record the steps taken to support, a person to make a decision before concluding that their decision is unwise.

6.7. There is a need to develop an approach across agencies which promotes questioning mental capacity when someone makes an unwise decision. This involves identifying and recognising patterns in behaviour and identifying situations in which it is appropriate to assess mental capacity. It also includes recognising when to refer to the Court of Protection for a determination on mental capacity and when to apply other legislation including the Human Rights Act 1998.

6.8. **Recommendation:** The KBSP should receive assurance from partners (through, for example, audit results, survey results, case studies, policy and procedure reviews, performance figures etc) that guidance and training for staff includes when to question and assess mental capacity; how to support people to make decisions and the actions to take when someone makes unwise decisions. This should also include the use of legal processes such as referral to the Court of Protection and when to use them.

6.9. **Self-neglect, safeguarding and coordination.**

6.10. There is a need to support staff to recognise that Lily and people who present with similar needs and challenges might be self-neglecting and that this can lead to safeguarding interventions to coordinate multi-agency information sharing and action. The individual actions by housing services, Adult Social Care and the Probation Service showed considerable determination and persistence and some information sharing. This was, however, transactional rather than relational and did not lead to a fully joined up approach.

6.11. **Recommendation**: The KBSP should receive assurance from partners (through, for example, audit results, survey results, case studies, policy and procedure reviews, performance figures etc) that multi-agency self-neglect protocols and processes are

available, that staff are aware of them, they include substance use and associated behaviours in the definition of self-neglect and that they prompt multi-agency information sharing, risk assessment and decision making.

6.12. **Contingency planning**

6.13. Plans for people with whom services struggle to engage should be formulated to acknowledge that the non-engagement may take the form of abusive or threatening language or behaviours. They should consider how, for example, someone who is behaving in such a way as to banned from a hospital might, at the same time, be admitted there. The plans should also be easily accessed by the staff who are likely to be in a position to implement them in busy situations where resources and time are stretched.

6.14. Whilst changes have been made to hospital processes for people with Personal Support Plans following Lily's death, more robust discharge planning for people with complex needs may be required.

6.15. **Recommendation**: KBSP should receive assurance from Bristol University Hospital (through, for example, audit results, case studies, policy and procedure reviews, performance figures etc) that the lessons from this review on the robustness of contingency plans for high impact users have been implemented

6.16. **Mental health and substance use**

6.17. There may be a need to consider how to assess the mental health needs of people who use substances and have episodic, short-term contact with mental health services. There may also be a need to determine whether mental health and substance use needs can be assessed together.

6.18. **Recommendation**: The KBSP should receive assurance from partners (through, for example, audit results, case studies, policy and procedure reviews, performance figures etc) that the mental health needs of people who use substances and have episodic, short-term contact with mental health services can be assessed and that patterns of attendance and presentation and concerns can be identified and are used as part of the assessment process.

APPENDIX 1: Contact with family members and consent.

There is a clear legislative expectation that the views of adults with care and support needs are valued and that their choices are respected and followed wherever possible. The Care Act, for example, recognises the importance of "beginning with the assumption that the person is best-placed to judge their situation" and places a duty on local authorities to make sure that:

- The person participates as fully as possible in decisions and is given the information and support necessary to enable them to participate

- decisions are made having regard to all the person's circumstances (and are not based only on their age, appearance or other condition or behaviour)

- any restriction on the person's rights or freedom of action is kept to the minimum necessary.

Section 1.14 of the Care and Support Statutory Guidance for the Care Act also states that, "*Considering the person's views and wishes is critical to a person-centred system. Local authorities should not ignore or downplay the importance of a person's own opinions in relation to their life and their care. Where particular views, feelings or beliefs (including religious beliefs) impact on the choices that a person may wish to make about their care, these should be taken into account. This is especially important where a person has expressed views in the past, but no longer has capacity to make decisions themselves*".

Practitioners often face a dilemma when balancing a person's views and wishes with the need to act to protect them from harm. S14.187 of the Care and Support Statutory Guidance for the Care Act states that "*…agencies should reach an agreement about confidentiality and information sharing which is consistent with the Caldicott principles that*:

- information will only be shared on a 'need to know' basis when it is in the interests of the adult

- confidentiality must not be confused with secrecy

- informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement

- it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk".

s14.188 of the Care and Support Statutory Guidance for the Care Act states that, "*Where an adult has refused to consent to information being disclosed for these purposes, then practitioners must consider whether there is an overriding public interest that would justify information sharing (for example, because there is a risk that others are at risk of serious harm) and wherever possible, the appropriate Caldicott Guardian should be involved. Confidentiality: NHS Code of Practice sets out guidance on public interest disclosure".*

There was a risk that should Lily, or another party, complain to the Local Government and Social Care Ombudsman or to the NHS and Parliamentary Ombudsman about contact with her family without her consent, then the Ombudsman might reach a finding of maladministration which might also include a payment of compensation.

Common law, the Human Rights Act 1998 and the General Data Protection Regulations (GDPR), supplemented by the Data Protection Act 2018, regulate the processing of personal data about living individuals in the UK.

The GDPR defines personal data as: "*any information relating to an identified or identifiable natural person ('data subject'); an identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person"* and sets out a number of principles covering its use and storage. Essentially, disclosure of confidential information is only allowed if consent to disclose is given, if disclosure is required by law or when it is justified in the public interest.

If Lily or another party, complained about a breach of the GDPR there is risk that this would have resulted in a fine.

It is unlikely that Lily's refusal to allow information to be shared with her family posed a risk to other people. However, even where there is no public interest concern, practitioners should also consider and assess whether or not a person has the mental capacity to make a decision. In Lily's case this could have included exploring the reasons why she did not want information shared with her family; and determining whether or not she understood, retained and used and weighed the information necessary to deciding that she did not want contact, in addition to her ability to communicate her decision.

Even if Lily had made a capacitous decision that there should be no information shared with her family, attempts by her family to contact services should not be rejected. The General Medical Council, for example, states that "*In most cases, discussions with those close to the patient will take place with the patient's knowledge and consent. But if someone close to the patient wants to discuss their concerns about the patient's health without involving the patient, you should not refuse to listen to their views or concerns on the grounds of confidentiality. The information they give you might be helpful in your care of the patient*".

The Royal College of Psychiatrists goes further in suggesting that professionals may initiate contact with others including family members, stating, "*There is nothing to prevent you, or any other healthcare professional, from receiving information provided by any third party about the patient, as receiving information does not equate to disclosure*. *Indeed, provided the circumstances do not involve disclosure of confidential information, a healthcare professional may actively request information without the patient's consent. This can be an important part of the risk assessment of a patient*".

The Consensus Statement from the Department of Health (2014) states "if the purpose of the disclosure of information is to prevent a person who lacks capacity from serious harm, there is an expectation that practitioners will disclose relevant confidential information". The document further indicates that where a person is at "imminent risk of suicide", this in itself

will raise significant doubts about their mental capacity. In such cases the practitioner must record their decision about sharing information and the justification for this decision.

The document further adds that the duty of confidentiality in no way prevents practitioners from listening to the views of family members and friends, who may offer a vital insight into the individual's state of mind, thus aiding care and treatment. Good practice also includes providing families with non-person-specific information such as how to gain access to services in a crisis, as well as support services for carers.

Despite this, the GMC strikes of a note of caution and warns that, "*You should, however, consider whether your patient would consider you listening to the views or concerns of others to be a breach of trust, particularly if they have asked you not to listen to specific people. You should also make clear that, while it is not a breach of confidentiality to listen to their concerns, you might need to tell the patient about information you have received from others – for example, if it has influenced your assessment and treatment of the patient. You should also take care not to disclose personal information unintentionally – for example, by confirming or denying the person's perceptions about the patient's health*".

There is a distinction here between a practitioner disclosing personal data (which includes health information) to a person's family against the person's wishes and receiving information from a person's family.

APPENDIX 2: Wellbeing

Section 1(2) of the Care Act (2014) states that:

"Well-being", in relation to an individual, means that individual's well-being so far as relating to any of the following:

a) personal dignity (including treatment of the individual with respect);
b) physical and mental health and emotional well-being;
c) protection from abuse and neglect;
d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
e) participation in work, education, training or recreation;
f) social and economic well-being;
g) domestic, family and personal relationships;
h) suitability of living accommodation;
i) the individual's contribution to society.

APPENDIX 2: HUMAN RIGHTS ACT

All public sector bodies, whether or they are directly or indirectly funded by the UK Government have a duty under the Human Rights Act to discharge the State's positive obligations under the European Convention on Human Rights:

- Article 2 – to protect life
- Article 3 – to protect against torture, inhuman or degrading treatment

- Article 5 – to protect against unlawful interferences with liberty, including by private individuals
- Article 8 – to protect physical and moral integrity of the individual (especially, but not exclusively) from the acts of other persons

APPENDIX 3: MENTAL CAPACITY ACT

The Mental Capacity Act requires a three-stage test of capacity to make decisions:

1. Is the person unable to make the decision? i.e. are they unable to do at least one of the following things:
   - Understand information about the decision to be made, or
   - Retain that information in their mind, or
   - Use or weigh that information as part of the decision-making process, or
   - Communicate their decision (by talking, using sign language or any other means)

2. Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors such as alcohol or drug use?

3. Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to? Individuals can lack capacity to make some decisions but have capacity to make others, so it is vital to consider whether the individual lacks capacity to make a specific decision at a specific time.

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