Safeguarding Adult Review on Mark
September 2018
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1. Introduction

The independent chair of the Safeguarding Adults Board agreed to the recommendation from the One Panel (Waltham Forest’s Think Family forum which takes referrals for local or statutory reviews and makes recommendations against the statutory criteria to the independent chair) to undertake a Safeguarding Adults Review for Mark who was stabbed to death by a friend. Mark had care and support needs due to self-neglect which appears to have been a result of alcohol and drug use, physical health needs, anxiety and low-level depression and was involved in criminal behaviour.

The One Panel agreed that Mark’s case met the criteria for a SAR in line with the Care Act 2014 and as noted in the Care and support statutory guidance

“SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult”

The purpose of SARs is described very clearly in the statutory guidance as to ‘promote effective learning and improvement action to prevent future deaths or serious harm occurring again’. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

What SARs are not is also explained: The purpose of a SAR is not to hold any individual or organisation to account. Other processes exist for that purpose, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation run by the Care Quality Commission (CQC) and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council etc.

The One Panel in conversation with the SAB chair agreed the focus for this SAR. The SAB had recently conducted two SARs which included issues of alcohol, drugs and self-neglect. Action plans are in place and work is underway to make improvements in practice in these areas.

In line with the Care and Support Statutory Guidance (revised in July 2018) for SAR, “the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined”. The One Panel noted when discussing Mark there were similarities with other cases where there was a person who was generating a lot of activity with several agencies at the same time and there did not appear to be a multi-agency approach.

It was therefore agreed that the focus of this SAR would be proportionate in light of the previous SAR and focus on the multi-agency working and approach with people who have complex needs in relation to their self-neglect caused by alcohol and drug use, mental health needs, criminal behaviour and involvement in ASB, with a view to exploring how as a partnership we could work together more effectively to improve the outcomes for residents.

The SAR was agreed in April 2018 and started in May 2018, and the review report was agenda for the SAB in September 2018.

The publication of this report was then delayed until after the trial of Carol Campling who was convicted of the murder of Mark in the summer of 2019 and sentenced to a minimum of 17 years imprisonment.
1.1 About Mark

Mark was 48 years old and lived in a housing association property. He moved to this block of flats in February 2017 as he was moved by the Local Authority due to regeneration of his block. He had a flat in a small block of low-rise properties. In the same block lived several people who also used alcohol and drugs and Mark became friends with them, and some of their friends who lived elsewhere who he had not known previously.

Mark is described as a friendly person who could hold a good conversation and had a knack of talking his way out of difficult situations. Mark generally managed to be everyone’s friend and tried to stay out of disagreements. The people that Mark made friends with at the block were involved in anti-social behaviour more frequently, and to a greater extent, than Mark. This sometimes meant that Mark was not the focus of agencies’ attention. There was considerable anti-social behaviour in the block and on a public area 5 mins walk from the block. This included making a lot of noise through shouting and criminal damage which disturbed and caused upset to neighbours, shop owners and members of the public walking past. Mark was at different times both a victim and perpetrator of physical assault within his group of friends.

Mark was diagnosed with Varices and Liver Cirrhosis as a result of alcohol use and was noted to have a history of depression, anxiety and sciatica. Mark was involved in criminal behaviour and showed signs of self-neglect and was frequently “cuckooed” when a friend took over his flat and changed the lock, so Mark was not able to enter. Mark at times requested support to address his addictions but was not able to stop his alcohol and drug use and often declined to accept support that was offered, primarily by the substance misuse provider.

Information about Mark’s family connections is very limited. Mark had a daughter that he was estranged from and a father that was listed as his next of kin but it is not known if Mark had any contact with him.

During the review practitioners were asked to share information about Mark as a person to enable this to come through in the review. Unfortunately, the agencies involved had limited information to share. Practitioners spoke about how Mark to some extent was often in the background and the other people in the same friendship group attracted more attention due to their more challenging anti-social behaviour. This review focuses on Mark as the person who was murdered, though we are aware that the other friends involved had the same but at times more complex needs as Mark and the issues of concern that we discuss for Mark would be similar for others involved as well.

Mark’s friendship group was challenging and at different times he wanted to be part of the group and thought of them as his friends and at other times felt frightened and anxious about the relationships with some individuals. It is one of these friends who have been charged with Mark’s murder.

As reviewers we decided to continue using the term friends as this best describes the nature of the close relationship that Mark had with them.
1.2 Methodology

The review has been carried out in a way that reflects the values and principles set out in the SCIE ‘Learning Together’ approach to reviews. The principles include:

- Avoidance of hindsight bias. That is understanding how different professionals saw the case as it unfolded;
- Providing adequate explanations - appraising and explaining; and
- Understanding how the specifics in this case can be used to generate wider understanding.

The systems approach provides a framework for considering the influences on practice by people. It helps us understand how and why things happened as they did and what affects an event or practice in one place has on another event, person or organisation.

The review was led by internal reviewer Suzanne Elwick (Head of strategic Partnerships. LBWF and external reviewer (who had no contact or knowledge of the case or agencies involved) Elisabeth Chapple, Superintendent, Metropolitan Police Service, Hammersmith & Fulham Borough.

The review team included frontline practitioners and managers from all the agencies that were involved with Mark. Members of the review team took the opportunity to reflect and examine practice and together created an environment of constructive challenge and were open and transparent about identifying when practice was not good enough. The reviewers thank the review team for their honesty and support in ensuring that the review process focused on learning and improving practice. The agencies involved are:

**Police**
- Waltham Forest Safer Neighbourhoods police team and local response team
- Police central statutory review team

**Waltham Forest Local Authority**
- Housing
- Neighbourhoods
- Adult Social Care

- Drug and Alcohol support provider
- North East London Foundation Trust
- Barts Health Trust
- Local Housing Association Provider
- London Community Rehabilitation Company

The aim of the review was to consider Mark’s experience and appraise the practice that he received to identify learning priorities for the Safeguarding Adults Board in order that it can understand the areas of development required for the people of Waltham Forest who have complex needs. The steps in the review were as follows:
1. Chronologies were requested from each agency who was involved with Mark and were consolidated into one “Significant Events Chronology”.

2. A SAR workshop was held with all agencies, including front-line staff and managers, to:
   - Appraise practice, identify themes and reflect on systems in place in Waltham Forest that support people in circumstances such as those experienced by Mark; and
   - Identify the learning that will deliver improved approaches to systems that deliver services and safeguarding to adults in Waltham Forest.

3. A second workshop was held where the review team focused on the draft findings.

4. A draft report was circulated for comment to the review team.

5. The final draft was circulated to CE of all agencies involved for sense checking.

6. The final report was submitted to the One Panel.

7. The report was presented to the Safeguarding Adults Board in September 2018.

1.3 Summary of events, based on the integrated chronology

The timeframe for the review was the year before Mark died, 15 Feb 2017 – 15 Feb 2018.

The integrated chronology gives a real sense of the chaotic lifestyle of Mark and his friends and the huge amount of time that services spent engaging with Mark and others around a range of issues including anti-social behaviour, violence, and health issues etc. The Housing Association received frequent complaints from the neighbours in the same block of flats about the anti-social behaviour of Mark and his friends, some of whom also lived in the same block. The complaints included shouting, arguing, fighting, and partying. Mark frequently asked the Housing Association to change the locks on his flat door because a friend had changed them to prevent him accessing his flat. This is cuckooing but does not appear to have been recognised as such at the time. The neighbours would also call the police and/or ambulance for Mark when he was collapsed in the block or nearby due to alcohol, drugs or as a result of being assaulted. Mark himself called police when he felt threatened by one of his friends or suspected he had been robbed or burgled and frequently was not then able or willing to make a formal complaint or statement. There was a clear sense that all agencies tried to work with Mark, although they did not take a multi-agency approach and this limited the impact of their engagement. A multi-agency approach would have involved all agencies involved with Mark coming together to share information and together explore how to approach Mark and discuss with him his support needs.

In this year there was substantial involvement from the Housing Association and Police (both Safer Neighbourhoods Team and local Response Team), at times on a daily basis.

Mark and his friends would often drink on the public area 5 minutes’ walk from the block of flats and visit the high street nearby. Mark and his friends were banned from many shops on the high street because they stole from them. The Police stated that their general approach was to pursue Mark in regard to his criminal activity and they did not consider referring him to the anti-social behaviour forum to consider a multi-agency approach to supporting Mark. Although during the year the Police completed 5 MERLINs on behalf of Mark which were sent through the MASH to Adult Social Care. The Merlins showed an increase in concerns about Mark. In August Mark said he had been assaulted by a friend and the police called an ambulance but Mark declined to go to hospital. A few days later Mark attended the local Police station to say he was frightened that his friend was going to hurt him, and he was anxious and depressed. Police completed a Merlin and advised him to go and stay with
his father. It is not known if Mark was able to stay at his father's. Later in August Police attended Mark’s flat when he failed to appear at court and found Mark injured. Police completed another Merlin. In October Police were called to Mark’s flat by a friend who was concerned because Mark was badly injured and said he had been beaten up by several people. Unfortunately, Mark was not able to make a full statement about this incident. Police were again concerned for Mark due to the level of his injuries and completed another Merlin. In December Police were called to Mark’s flat by neighbours complaining and Mark was found to be drunk. The officers described Mark’s flat as “being filthy and disgusting” and the concerns about Mark were increased from the previous Merlin which noted signs of self-neglect. When received by Adult Social Care all the Merlins were rated as “Amber” and had the same outcome which was a referral to the alcohol and drug service provider which is not appropriate practice and is discussed in more detail in Finding 3.

The Safer Neighbourhood Police worked very closely with all the neighbours to try and resolve the issues related to ASB and manage the community relations by demonstrating that the police were listening to their concerns. For example, the police held a meeting for all the neighbours at the police station but this did not include other relevant agencies in a position, and with a responsibility to act, which includes Adult Social Care, Housing, Health services etc.

The approach of the Housing Association was that of a landlord. The Housing Association demonstrated patience in regard to Mark’s tenancy in the context of the significant and frequent complaints. There were many examples of good communication and information sharing between the Housing Association and the Police.

The Housing Association attempted to resolve the issue by applying for injunctions that would prevent the friends entering each other’s flats and when this did not work the Housing Association finally sought to end Mark’s tenancy as a result of his behaviour, which included a range of anti-social behaviours such as complaints from other tenants in the block about Mark banging on their door late at night, on-going complaints about violent arguments between Mark and others at his flat, and loud noise disturbance in general. Neither the Police nor the Housing Association made a referral to the anti-social behaviour forum for Mark. The Housing Association contacted the community safety team to discuss the case and did not receive a response. Unfortunately, the Housing Association did not escalate or pursue with another team about their concerns. All agencies in the borough are actively encouraged to escalate if they do not receive what they feel is the appropriate response in relation to concerns, in line with the escalation process on the Safeguarding Adults Board. The Housing Association did make safeguarding referrals for two of Mark’s friends.

During the year Mark attended the Emergency Department at the local hospital on 8 occasions. Mark attended hospital for a variety of reasons including when he had been physically assaulted, and when he was experiencing health issues as a result of his alcohol use. On one occasion London Ambulance Service was called but Mark refused to go to hospital. In July Mark went to hospital due to vomiting and pain. He requested detox and spent nearly four days in hospital. Mark was then referred to the local alcohol and drug service provider. In line with their missed appointments policy the hospital closed Mark’s case when they felt he did not engage.

On 17 October 2017, Mark was sentenced to a 12-month Community Order with a Rehabilitation Activity Requirement and an Alcohol Treatment Requirement (ATR) for 3 counts of shoplifting. The delivery of the Order was managed by the London Community Rehabilitation Company (CRC). As part of the Order Mark was again referred to the alcohol and drug service provider (Mark is reported
by the provider to have attended the minimum number of sessions required to ensure he fulfilled the order). The Offender Manager worked in partnership with the provider to share some concerns, and also to make sure that Mark was attending and engaging with treatment to address his substance misuse. The Offender Manager tried to motivate Mark to take action in improving his health and addressing his addiction. Mark spoke to the Offender Manager about the issues he was experiencing with his friends and the local police. There was no evidence to suggest that the Offender Manager had liaised with the local Police or the Housing Association.

2. Findings and questions for the board
The review appraised the practice that Mark had received and then asked how the system usually works in cases similar to that of Mark’s. In exploring areas of practice through identifying what worked well, what good practice would look like and encouraging reflection we are able to develop our understanding at system level of how multi-agency safeguarding partners work together and where there is scope for improved practice.

The review identified three main areas where practice can be improved to deliver the service that vulnerable adults should expect.

1. Working with people who have chaotic lifestyles, including anti-social behaviour (ASB), who do not meet the criteria for adult social care safeguarding creates challenges for the practitioners working with them and trying to provide support. Practice and outcomes for vulnerable adults are being affected by organisations not working within a multi-agency approach.

2. Difficulties in needing to define a person’s support needs within the context of services threshold/criteria creates barriers for practitioners in understanding when and to whom they can refer, resulting in adults not receiving the support and help they require.

3. Recognising and naming self-neglect in the context of adults with capacity who are misusing alcohol and drugs is a challenge for the multi-agency partnership. This can mean it is not identified when self-neglect becomes a safeguarding issue.

2.1 Finding 1
Working with people who have chaotic lifestyles, including anti-social behaviour (ASB), who do not meet the criteria for adult social care safeguarding creates challenges for the practitioners working with them and trying to provide support. Practice and outcomes for vulnerable adults are being affected by organisations not working within a multi-agency approach.

A key challenge for services is that there is a lack of formal opportunities for information sharing and joint working. These are limited due to a lack of accepted practice of joint working outside of the
formal framework of Safeguarding as defined in the Care Act 2014 and the Pan London Safeguarding Adults Multi Agency Procedures.

In relation to adults, there is no guidance on how to work when the formal process does not define this. This includes consideration of how and when (and whether it is possible) to share information on adults that professionals are concerned about but would not yet meet the threshold for adult social care safeguarding. Practitioners lack confidence, particularly when adult social care is not involved, to make decisions to share information and contact other agencies. The guidance for adults does not reflect the concept of a lead professional, professionals meeting or team around the adult meetings, practices that are common in children services.

How are these issues evident in this case?

There were a number of different agencies and professionals working hard with Mark during the last 12 months of his life, however they did not all come together as one group to share information or plan for his care and support. There is evidence that some agencies worked closely with one other agency with whom they already had an established relationship. For example, the Housing Association and the local Police worked very closely together and were working hard to secure a better outcome for Mark and the rest of the tenants in the housing block. The Police showed commitment and determination to resolving the issue in the block, and committed a large of amount of resource, often visiting the housing block daily. The Police communicated frequently with the other tenants in the block and organised a meeting of tenants at the police station, which is good practice, to gather information and show the tenants the Police were working to resolve the issue. The Police raised the situation with their managers who advised on a strategy of addressing Mark and his “friends” criminal behaviour. Unfortunately, neither the Police, nor the Housing Association collaborated with other agencies or referred to ASBRAC – Anti-Social Behaviour Risk Assessment Conference. Nor did they seek to hold a multi-agency meeting to explore the complex situation that affected not just Mark but his friends too.

No agency considered a referral to the anti-social behaviour forum ASBRAC. The review team spoke about the group of people that Mark drank with and understood that Mark was often not the focus of their attention as the two other people involved had a higher level of ASB and criminal behaviour. Mark was often quieter and in the background. In general, the Police saw Mark as a criminal and therefore focused their action on challenging his criminal behaviour. The exception to this was on the 5 occasions that the Police response team completed a Merlin and referral to Adult Social Care for Mark when they recognised his vulnerability.

The Housing Association has a policy on ASB; they confirmed that this case should have been referred through the policy. In this case, the front-line member of staff at the time reported this to their manager but the appropriate action was not taken in line with their policy. The manager has since left the organisation for other reasons and all staff have received training around these issues using this case as an example.

This was a situation that required a multi-agency approach and it was not possible to resolve the situation without that.

There is evidence that CRC liaised regularly with the Substance Misuse provider in sharing some concerns, and also making sure that Mark was attending and engaging with treatment to address his substance misuse which is the expected practice particularly in relation to Mark being on a Drugs
Rehabilitation Order. However, CRC did not liaise with the local Police. CRC reflected that it would have been appropriate for the offender manager to contact the local Borough Intelligence Unit, to try and further understand some of the concerning behaviours caused by and to Mark. There is evidence that there were several areas which caused concern throughout CRC’s work with Mark which should have prompted a discussion with Adult Social Care to explore Mark’s deterioration and increase risk. This included Mark repeatedly turning up for appointments drunk, several hospital admissions for serious physical health issues and when he had been assaulted, Mark’s arrest for ASB and potential eviction, and when Mark was reported to be looking unwell, not eating or looking after himself. In addition, there is no evidence to suggest that the Offender Manager discussed the concerns with their line manager. At the time in CRC there was 1 manager covering 2 teams and this may have been a factor in the offender manager seeking advice and support.

The contract for the drug service provider changed during the timeframe of the review. The previous provider’s contract changed in June 2017. In the previous drug service provider, the practice was to store the information about the Merlin and not to respond or contact other agencies to discuss. This practice has changed with the new provider and is discussed in Finding 2.

This had implications for what agencies knew and understood about what was happening with Mark. Agencies were working within their own remit, not going outside of this and not communicating with other agencies which resulted in a limited understanding of the situation and the wider context. This directly impacted on their ability to effect change. The approach of agencies appears to have been more reactive than strategic which again impacted on their ability to effect lasting change.

This review has highlighted the difficulties generated by ‘silo working’ and situations where workers are not confident about whether they can or should engage others in collective working to develop a ‘team around the adult’.

All agencies acknowledged that they had generally worked in isolation, sometimes in their pairs. Agencies advised they did not think about contacting others and did not discuss with Mark seeking additional support from other agencies. This was not an issue of agencies feeling concerned about gaining consent to share information. Consent was not discussed with Mark because no agencies sought to share information. The Police made 5 referrals to MASH when they were concerned about Mark’s safety and wellbeing. These referrals were screened by adult social care; no contact was made with Mark by ASC which would be expected practice. Adult social care then referred to substance misuse services, and there was no follow up by the Police. The referrals appear to be seen as an end in themselves.

A member of the review team noted, that just making referrals about safeguarding should not be viewed as the end of that agency’s responsibility in relation to that person’s safeguarding needs. Safeguarding is everyone’s responsibility and practitioner’s responsibility does not end because you have referred someone to another agency. The Waltham Forest SAB promotes an escalation policy which stresses the importance of professionals taking responsibility to escalate if they feel that the risks they are identifying are not being seen or acted on. In this situation it would have been appropriate for the police to escalate their concerns to their managers because they had made repeated Merlins and there were escalating risks for Mark. There was no holistic risk assessment of Mark, several agencies had valuable information, but this was not brought all together. There was a lack of professional curiosity.
There were several occasions when agencies made attempts to resolve the issue through formal process such as eviction notices, harassment notices, injunctions etc. However, for various reasons these processes were not followed through or enforced. The Housing Association and Police worked in partnership around these processes but did not at any time seek support or advice from other agencies. If any of these processes had been successful, this may have resulted in Mark being evicted. It is noted however that if this had been the case it may have led only to moving the problem, in that Mark as a vulnerable adult would have presented as homeless and may have been placed in temporary accommodation while his homeless claim was investigated.

No one agency had a full picture of what was happening in Mark’s life and it is possible that if agencies had shared information, the smaller concerns they all had may have become a larger more complex concern that may have reached the level where agencies felt a referral to ASBRAC would have been appropriate. Agencies advised they did not ask Mark if they could share information with others as they were not thinking about how to work with other agencies. This lack of multi-agency approach led to missed opportunities to share information and effectively plan intervention and support for Mark.

**Does this happen in other cases?**

Members of the review team were able to identify many service users similar to Mark, presenting with more complex needs and high risk with a reluctance to engage with services.

A robust risk assessment, preferably multi-agency, that includes the views of the adult and their personal network is central to good planning in relation to care for adults when in the pre safeguarding space. However, in contrast to children services, there is no formal guidance, culture or practice to support professionals to take this type of approach and identify a lead practitioner when the case is in the pre safeguarding space as Mark was. There is no culture of multi-agency working in this type of case, where it appears that agencies are not familiar or comfortable in coming together to discuss their concerns about individual people.

**Is this specific to Waltham Forest?**

Discussion in the workshop highlighted that there is not a shared understanding of when and how it is appropriate to call professional meetings to share concerns about adults presenting as high risk who are in the pre-safeguarding space and below safeguarding threshold, yet who have capacity and support needs.

**What are the implications for the multi-agency adult safeguarding system?**

Although Mark would not have met the criteria for Adult Social Care safeguarding at this point the discussion about risk, prevention and monitoring are relevant. If practitioners do not come together to share information, risk assess and plan intervention and then monitor the situation, people like Mark will not be provided with the support they need, and no-one will notice if their needs increase to a level that meets safeguarding.

A safe system requires all professionals to be competent and confident in their role and responsibilities. Practitioners need to feel empowered and confident about their own professional opinion and make informed decisions to support effective care planning in the best interests of adults in the most challenging of circumstances. This is more likely to happen in a system where workers
know when and how they can share information and are confident that other professionals will come together to develop the best client-centred care plan possible.

Silo working, or working with one partner only, however well intentioned, does not support informed care planning. Without effective and recognised mechanisms in place for agencies to share information and jointly manage risk there is a likelihood of poorer outcomes for vulnerable adults.

Questions for the board

1. In the context of no national guidance and the lack of culture and practice of agencies taking a multi-agency approach, how can the board promote culture change to achieve positive multi-agency work and appropriate information sharing?

2. How can the board support and empower practitioners to value and act on their professional judgement? (“If it doesn’t feel right it’s not right.”)

2.2 Finding 2

Difficulties in needing to define a person’s support needs within the context of services threshold/criteria creates barriers for practitioners in understanding when and to whom they can refer, resulting in adults not receiving the support and help they require.

Thresholds for services are an established part of adult services and guidance about thresholds can promote understanding about roles and responsibilities for different agencies and help practitioners navigate the landscape of available support for clients.

Services need to be designed with a clear sense of purpose; what needs the service is able to address and what outcomes the service aims to achieve. This is often described as the “threshold” or “criteria” for services.

Thresholds are important for the above reasons but as we know, when supporting adults with complex needs a pragmatic approach is sometimes required.

If thresholds are seen as a barrier by practitioners, referrals to agencies are not made due to a perceived idea that the threshold will not be met because the adult’s needs do not fit with the prescribed terms of the threshold and therefore no point in referring.

How are these issues evident in this case?

Practitioners did not know how to define Mark’s needs and therefore struggled to make a plan on the best way to intervene and address his support needs. There were many practitioners involved with Mark but he was offered limited support to assess or address his needs. It is possible that some practitioners saw Mark as someone living a chaotic lifestyle, as someone who misused alcohol and drugs and labelled him as such as someone who was not able to change.

Mark was not identified as self-neglecting except in the Police Merlins. The Merlins were the exception to this but were not followed up and did not result in any additional support for Mark.

At the time, the threshold for referral to ASBRAC was not thought by practitioners to have been met. One of the potential reasons for this was, in comparison with other clients, Mark’s issues were thought to be less acute.
Mark was at different times an alleged perpetrator and victim. There is early work in progress to develop a more non-binary approach to recognise the complexity of this type of situation during the timeline and presently the default is still perpetrator/victim which would have created challenges for practitioners in terms of where best Mark should be referred to.

One reflection in the SAR workshop was that some practitioners thought that Mark could have been seen as experiencing domestic abuse due to the intimate nature of the relationships he had with his friends, some of whom were allegedly assaulting him.

Although some of Mark’s needs did meet the criteria for a service or intervention, others did not. The consensus in the SAR workshop was that Mark had complex support needs that were not being addressed. These included his self-neglect, alcohol and drug use, mental health concerns, physical health needs, anxiety and depression, criminal behaviour/anti-social behaviour. This is the significant issue and highlights the need for agencies to be pragmatic in relation to thresholds and criteria to enable people with complex needs to receive the support they need. The test for this was that many of the agencies involved were interacting with Mark on an almost daily basis. This should have signalled the need for agencies to talk about Mark, with Mark, and together.

The Housing Association did attempt to try addressing some of the problems through the use of injunctions preventing Mark and two of his friends from entering each other’s flats. The court initially agreed the injunctions but later the court overturned the injunctions. Also the injunctions were quite complex so coupled with the time delay of the injunctions going on the Police National Computer meant that the injunctions could not be enforced.

Agencies reflected during the review that they could not single out one person to refer to ASBRAC. If they were going to refer anyone it would have been the whole group and they were not sure if this was possible. If this had been the case, then Mark may have been included in a group referral.

**Does this happen in other cases?**

Practitioners were able to discuss other cases in which there is the same situation with adults with complex needs who do not clearly meet the criteria for support services.

**Is this specific to Waltham Forest?**

Our understanding and approach to supporting adults is still developing and subject to much debate. Public opinion reflects these dilemmas. In cases where practitioners have intervened, they have been criticised for going against someone’s human rights to choose and also criticised for not intervening and something terrible happening to someone. The balancing of human rights and being protected from harm are key issues in safeguarding adults and will always require a careful balance and judgement.

A recent community care article and the comments this prompted by different professionals illustrates this [http://www.communitycare.co.uk/2017/04/03/call-tougher-adult-safeguarding-standards-mans-murder/?cmpid=NLC%7CSCSC%7CSCDDDB-20170404](http://www.communitycare.co.uk/2017/04/03/call-tougher-adult-safeguarding-standards-mans-murder/?cmpid=NLC%7CSCSC%7CSCDDDB-20170404)

The article is about a SAR review completed on a case where some similar elements of a man who was a chronic alcohol user and declined the consistent and persistent support that was offered to him. He died when he was killed by a fellow drinker. The SAR panel urged authorities to consider how...
adult safeguarding practices could be better aligned with those that exist within child protection services going forward.

What are the implications for the multi-agency adult safeguarding system?

There are implications for how we support adults with complex needs, how as a partnership we understand our roles and responsibilities and the ways in threshold/criteria are designed and enforced.

As a partnership we need to explore ways of working that enable and empower practitioners to have a more flexible and pragmatic approach that encourages and enables others to refer people who would otherwise not meet criteria or thresholds for referrals.

If many different agencies are trying to support/work with an individual it would suggest that it would be good practice to create a multi-agency approach and have a discussion together.

Questions for the board

1. How can the Board create an effective forum to discuss people in similar situations to Mark?

2. How can the Board influence services in relation to their thresholds and criteria to be pragmatic to support people who do not totally fit their criteria?

2.3 Finding 3

Recognising and naming self-neglect in the context of adults with capacity who are misusing alcohol and drugs is a challenge for the multi-agency partnership. This means self-neglect is not identified or when self-neglect becomes a safeguarding issue.

Supporting adults who have capacity, yet misuse drugs and alcohol, may be self-neglecting, do not want to engage with services, and are below the Adult Social Care safeguarding criteria, presents many challenges to practitioners. Practitioners need to weigh up the right to self-determination and autonomy, with evidence of self-neglecting behaviour which may be very negatively impacting on the person’s quality and length of life. And for some situations also consider if the behaviour now meets the safeguarding threshold. It could be argued that this balance or dilemma is something that makes adult safeguarding fundamentally different or more complex in comparison to child safeguarding.

Naming self-neglect is complex and challenging. There are indicators of self-neglect but there is no precise definition that enables a consistent approach for practitioners and practitioners have different views. Terminology used reflects this challenge, in assessment terms such as “poor life choices”, “making difficult decisions”, or “a lifestyle choice”.


If we fail to recognise and name self-neglect, we are less likely to be able to identify when self-neglect becomes a safeguarding issue. A community care article reflects this when reporting on a review completed on a case similar to Mark. It was noted that “The failure to recognise that his inability or
unwillingness to engage with services was a risk in itself."

How are these issues evident in this case?

The majority of the agencies did not name self-neglect. The exception was the Police who made a referral to MASH. The Police made 5 MASH referrals which when read together show evidence of increasing concerns and Mark’s increasing needs. The referrals appear to have been reviewed in isolation of each other. There is no reference in the later referrals to previous referrals and no reference to the increasing level of concerns. The later referrals name self-neglect as a concern and referenced the physical environment in which Mark was living. At the time the referrals were reviewed by Adult Social Care (ASC) working alongside the MASH. The social worker who reviewed the Merlin would have made a decision as to whether to gather information from other agencies as part of their screening process. It appears that for each Merlin no contact was made with Mark and no additional information was gathered. The action of the ASC was the same each time, to refer to the drugs provider because they believed that the provider was working with Mark. Mark was often not engaging with the provider and so they were not in contact with Mark and therefore not able to provide any support. This shows a significant lack of professional curiosity, poor risk assessment and lack of using historical context when reviewing referrals by ASC.

Unfortunately, the unidentified risks from the review of the Merlin were compounded by the standard of practice by both drugs providers. The previous provider in receipt of the referrals at the time stored the information on the client file and the case worker was informed. There was no active response to referrals under the previous provider, which was very poor practice. A new service provider took over the contract in June 2017 and it took some time for the policies and procedures of the new provider to be embedded so the same practice was still in place when the final Merlin was sent in late December 2017. The practice in the new provider is now very different. All Merlins and referrals are discussed in line with the providers safeguarding policy and where appropriate a referral is made to adult safeguarding. The adult safeguarding policy makes clear that sharing information when there is risk of safeguarding is good practice.

Towards the end of the timeframe of review there was an increase in the physical violence that Mark was experiencing, he was reporting that he felt frightened and his physical health was continuing to deteriorate in response to his continued heavy drinking. This was a missed opportunity to explore further, follow up referrals and/or work with others who were interacting with Mark. On receipt of the last Merlin in December it would have been expected practice for ASC to seek information from other agencies to risk assess if safeguarding enquiries were appropriate. There was a lack of professional curiosity by all agencies, except the Police at this point.

When Mark attended hospital in July he agreed to detox. He was found in a public place intoxicated with alcohol. He was assessed by the alcohol liaison nurse. Mark advised he was drinking 18-20 units of alcohol a day (this is the equivalent of almost 2 bottles of wine). A screening tool was used during the assessment, indicating moderate withdrawal symptoms and severe alcohol dependency and a harmful drinking pattern. The assessment notes no evidence of deliberate self-harm to self or others. The assessment identified that Mark had liver disease for which Mark had an appointment with the Liver clinic which he did not attend. The service who completed the assessment advised that they were assessing Mark’s mental health for sense of self harm or harm to others. In this assessment practitioners are not looking for self-neglect, they are assessing alcohol misuse problems and risk
assessing for immediate self-harm which may lead to a Mental Health Assessment, which suggests a different lens than would be used to identify if someone was self-neglecting. This raises interesting questions regarding how self-neglect is identified by this service.

**Does this happen in other cases?**

At the SAR workshop agencies spoke of other cases which were the same as Mark’s with the same dilemmas and challenges in relation to identifying self-neglect and understanding when it was a safeguarding concern. The issue of identifying self-neglect and potential general safeguarding concerns in the service for people using alcohol and drugs as discussed above demonstrates this happens often.

**Is this specific to Waltham Forest?**

Research into cases of self-neglect by Preston Shoot and Braye (SCIE Fact Sheet 46) acknowledges the particular difficulties for front line staff who are working with adults who are self-neglecting and reluctant to engage with practitioners and the additional challenge for practitioners to recognise when self-neglect becomes a safeguarding issue.

Since the Care Act 2014 and the requirement to complete Safeguarding Adult Reviews there have been numerous SAR published in relation to issues of self-neglect, the pre-safeguarding space and safeguarding.

**What are the implications for the multi-agency adult safeguarding system?**

Practitioners do not feel equipped or empowered to recognise and name self-neglect particularly when alcohol and drugs are involved. There is a lack of confidence about when self-neglect becomes safeguarding, compounded by the lack of multi-agency working. It is important that practitioners are able to have discussions with others to explore peoples’ views and perceptions, so we do not have lone practitioners having to make these complex decisions on their own.

In the SAR workshop a manager noted that we put the onus on the person who is living a chaotic lifestyle, often under the influence of alcohol and drugs, involved in challenging relationships with others, anti-social behaviour etc. to say they want help and to work with services in a coherent manner. Services need to be able to respond to work alongside people who are in this situation in a flexible and pragmatic way that meets their needs and from their frame of reference.

It is noted that one of the SAB priorities since April 2018 is self-neglect and work is in progress to address the issues raised by this finding.

### 3. Board questions

1. How can the SAB assure itself that the work being delivered by the self-neglect task and finish group will adequately address the issues raised by this finding?

2. How can the SAB assure itself that people with high level of complex needs are identified by practitioners across the partnership?
3. How will the SAB ensure that the development of the Adult Social Care front door service will improve practice in relation to referrals, in particular in relation to use of historical context, risk assessment and professional curiosity?

4. **Summary of learning already undertaken by agencies**

   **Alcohol and Drugs Provider** - The provider has completed an internal review of their practice and identified the need for staff to feel confident about raising any issues of concern in the team meeting and to use the in-house safeguarding lead as first point of contact, or with the national lead if in-house safeguarding lead was not available or unable to make a decision.

   **London Community Rehabilitation Company** – A Death of an Offender Under Supervision Report was completed with the Probation Staff Member and their Manager which identified some good practice and some areas for improvement which have been used to promote improvements in practice in the service. Mandatory training has been delivered across all of London CRC. It was a two-day training event that focused on the safeguarding of children and adults and how we consider, record and action any information or concerns. However, it is acknowledged that more enhanced adult specific safeguarding training would be beneficial to frontline staff, specifically around the area of Service User consent, and those presenting with self-neglect. This identified training need has been raised with the Training and Development Team.

   **Housing Association** – Practice was reviewed on this case and this identified that the practice was not in line with the policy and that when concerns were escalated by front line staff to a manager, they did not follow the procedure. This manager no longer works at the HA. It was identified that it was important to raise awareness with all staff throughout the year of policies that they may not use often such as the ASB policy.

   **Police - Waltham Forest Police** - What Mark’s tragic death tells us is that we still have work to do in shifting our safeguarding response from ‘policy’ to ‘people’, to make safeguarding personal. The difficulties officers experienced securing material change in the safeguarding of Mark, while following policy, means that our policies need to be updated to factor in a mechanism and culture that facilitates escalation. Mark’s circumstances, including the risk that he faced from others, warranted a complex strategy meeting and collective action, rather than a reliance on risk referrals between agencies. The strategic partnership will have to establish better structures and processes to manage adults with complex high vulnerability risks.

   **Central Statutory Review Team Police** - Upon detailed review and consideration of the many Police contacts on this case, it is apparent not only that the officers concerned correctly followed current policies and procedures, but also that they went over and above prescribed levels of expectation, to make efforts to resolve the problems arising within proximity of Mark’s home address.

   It is apparent that where concerns for Mark’s welfare were evident, PAC reports were generated. This generated report meant that appropriate onward referral mechanisms were used. Those reports ultimately resulted in onward referrals to drug and alcohol services to try to support Mark. It would be my view that those referrals appeared to be an appropriate response, considering the level of concern evidenced in Mark's case.
As a result of this review I would consider this case to be an example of good practice from the local Neighbourhood Policing Team, who was doing their utmost to support Housing in their attempts to evict some or all of these tenants.

I am satisfied that the Officers who dealt with Mark were appropriately trained and suitably knowledgeable about Multi Agency cases and in the circumstances, Mark would not have been considered as a vulnerable adult by definition. However, there were some areas of concern which were appropriately referred to Adult Social Care for onward consideration. As a result of this review I do not feel that there are required areas of learning for the MPS, and the current policy regarding the recording of and referrals for cases of Vulnerable Adults, in my view, remains appropriate.

**Adult Social Care** – The findings of this case in relation to ASC’s response to the Merlins has been shared with Team Managers and Heads of Service and the process and practice of ASC related to Merlins received into ASC is being reviewed. The findings of this case will be used to underpin this. This includes safeguarding and non-safeguarding referrals. Safeguarding Adults Practice Framework sessions are being delivered by the Safeguarding Adults and DoLs Service; chronologies and risk assessment are integral to this. The ASC Social Care database Mosaic prompts staff to consider any previous raised concerns. Safeguarding Adult Enquiry Officer and Safeguarding Adult Manager is being delivered and chronologies, self-neglect, professional curiosity and risk assessment are integral to this. The learning from this SAR will be the focus of the next Safeguarding Practice Forum in ASC. A further development is the creation of an integrated safeguarding (children and adults) hub which will deliver a Think Family response to all safeguarding matters and high-risk referrals, for a timely, proportionate and effective partnership response.

**Local Authority Neighbourhood Management Team** – Although this case was not referred to ASBRAC, this review highlighted that with organisational changes there is a need to highlight ASBRAC and empower professionals to use their judgement in making a referral. The referral process into ASBRAC, including the risk matrix is under review to enable professionals to refer cases into the multi-agency forum without the requirement to meet the threshold of a high-risk case. It is accepted that the current generic risk matrix is a subjective process, open to interpretation and can be prohibitive; this will be simplified if possible. Professionals will be required to present their case to the conference and a decision will be taken to either accept the case or to refer it to another multi-partnership forum such as the ASB Partnership Meeting. This will be a 2-way process where cases can be escalated to ASBRAC or referred back to the ASB Partnership for monitoring and oversight of lower risk cases. The ASB Partnership meeting will report into the monthly ASBRAC.

High risk cases that are accepted at ASBRAC will also now be referred to the MASH for discussion at the Daily Risk Management Meeting (DRM) where appropriate, for example where there is domestic violence. This will further safeguard vulnerable adults that are deemed to be high risk.

The profile of ASBRAC will be raised with all partners including external agencies and registered Social Landlords.
4.1 Other learning

There were complexities regarding the injunctions sought by the Housing Association which requires further exploration. There was also a delay with the injunctions being placed on the Police National Computer for reasons unknown.

Not all the police team enforced the injunctions in the same way and when police did enforce the injunctions and took people to court, the judge often decided no further action would be taken and criticised police taking the offenders to court despite police following the requirements of the injunction.
Glossary

Alcohol Treatment Requirement (ATR)

The Alcohol Treatment Requirement (ATR) focuses on offenders who are dependent on alcohol or whose alcohol use contributes to their offending.

Anti-Social Behaviour (ASB)

Anti-social behaviour covers a wide range of unacceptable activity that causes harm to an individual, to their community or to their environment.

Anxiety

Anxiety is a feeling of unease, such as worry or fear that can be mild or severe.

ASBRAC

Anti-Social Behaviour Risk Assessment Conference

Care Act 2014

The Care Act 2014 is legislation that sets out in one place, local authorities’ duties in relation to assessing people’s needs and their eligibility for publicly funded care and support.

Community Order

A community order consists of various requirements, which differ according to the individual offender and the offence committed.

Community Rehabilitation Company

Their role is to manage the majority of offenders under probation supervision. CRC work alongside the National Probation Service, which manages offenders who have been assessed as presenting high risk of harm to others.

Cuckooing

Cuckooing is the term used to describe the actions of gangs who travel to towns and take over the homes of vulnerable people in order to deal drugs.

Depression

Depression is a mental disorder that causes people to experience depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration.

Liver Cirrhosis

Liver Cirrhosis is a complication of liver disease that involves loss of liver cells and irreversible scarring of the liver.

MASH
Multi-Agency Safeguarding Hub

**MERLIN**

Merlin is a database run by the Metropolitan Police that stores information on children who have become known to the police for any reason.

**One Panel**

The One Panel is Waltham Forest's Think Family forum which takes referrals for local or statutory reviews and makes recommendations against the statutory criteria for safeguarding adult reviews and local reviews/national review (previously known as serious case review) to the relevant board chair.

**Safeguarding Adults Board (SAB)**

The Safeguarding Adults Board represents organisations and agencies involved in safeguarding adults with care and support needs.

**Safeguarding Adults Review (SAR)**

Safeguarding Adults Review is a multi-agency process which seeks to determine what relevant agencies and individuals involved could have done differently, which may have prevented harm or a death. The purpose of the review is for all agencies to learn from findings.

**Sciatica**

Sciatica is when the sciatic nerve, which runs from your hips to your feet, is irritated.

**SCIE**

Social Care Institute for Excellence

**Self-Neglect**

Self-neglect is a general term used to describe a vulnerable adult living in a way that puts his or her health, safety, or well-being at risk.

**Substance Misuse**

Substance misuse is the harmful use of substances, (such a drugs and alcohol) for non-medical purposes.

**Varices**

Varices are abnormally dilated vessels with a tortuous course. Varices usually occur in the venous system, but may also occur in arterial or lymphatic vessels.