Cheshire East Safeguarding Adults Board

Safeguarding Adult Review – ANTON

Draft and confidential

Mike Ward

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Contents

1. Introduction

Anton was a 64 year old man of Slovakian (White European) origin with a limited understanding of English. In the last two years of his life, concerns were expressed in relation to Anton self-neglecting and about possible financial problems and financial abuse. In the last months of his life, his health was increasingly poor: he was reporting stomach pain and the inability to keep food down and as a result he was not eating properly and was neglecting his personal care and home environment. He was found dead as a result of pneumonia, in his property in November 2021.

The circumstances of Anton's death were referred to the Cheshire East Safeguarding Adult Board for consideration as a Safeguarding Adult Review (SAR) by both the Designated Safeguarding Officer at his Housing Association and an Advanced Practitioner in Cheshire East Council. The SAR Referral Panel (CSPR) considered the case in January 2022. It was agreed that the case highlighted a number of areas of potential learning; therefore, it was decided that that a SAR should be undertaken.

This SAR covers a period from November 2019 until Anton's death in November 2021. A multi-agency panel of the Board set up to oversee the SAR identified those agencies that had or may have had information about Anton during this period and sought information from them in the form of an Independent Management Report. Agencies were also invited to include any other information they considered relevant outside the time period identified and draw it to the attention of the panel. The multi-agency panel commissioned an independent author to complete the review.

2. Purpose of the Safeguarding Adults Review

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

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

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

3. Independent Review

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

4. Methodology

Following the agreement of terms of reference for the review (see appendix 1), the author was supplied with a series of relevant documents:

- A briefing template from each agency that was completed for the CSPR meeting - this contained basic information on the case and a chronology.
- The notes of the CSPR meeting that agreed to proceed to a SAR.
- An Independent Management Report from each agency involved.

The following agencies were involved in the process:

- Adult Social Care
- GP / Primary Care
- North West Ambulance Service
- Cheshire Constabulary
- Your Housing Group
- Local Floating Support Service - Concrete Housing
- Mid Cheshire Hospitals NHS Foundation Trust

The following had more limited contact and provided more limited information.

- CVS – Crewe
- Salvation Army (supported with Anton food on one occasion)
- Stroke Association
- Cheshire and Wirral Partnership NHS Foundation Trust

An initial SAR Panel meeting was held in April 2022 to discuss the process and timeline of the review. A Practitioner Reflection Day was held on 21st July 2022 and contributed a range of thoughts and views on Anton and his care.

All this information was analysed by the author and an initial draft of this report was produced and went to the Review Panel in September 2022. Further changes were made over the next two months, and a final draft was completed in December 2022 and was approved by the SAB in April 2023.

5. Family contact

An important element of any SAR process is contact with family. It is known that Anton had a brother living in England but there does not appear to have been close contact in the period under review. It was also suggested that he may have had a son, possibly still in Slovakia, again there does not appear to have been any contact in the

last two years of Anton's life. A couple of friends / supporters are identified in the chronology – an older male neighbour and a young Polish man who positively supported Anton at certain points. However, these relationships do not seem to have been active towards the end of his life. As a result, there has been no family or informal carer involvement in the development of this review.

One professional who knew Anton well, and who was a strong advocate for his needs, did contribute via the Practitioners' Event and this allowed the reviewer to have a more detailed picture of Anton and his needs. The author is grateful for her insights.

6. Parallel processes

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

7. Terms of Reference

The terms of reference for this review are included in Appendix 1. These informed the development of the Independent Management Reviews and the thinking about this SAR. However, they have not been used to structure this review because the review process opened up new learning about the themes to be prioritised in the report and how that material should be presented.

8. Background and personal Information

Anton was a 64 year old man who was found deceased in his property in November 2021. He was of Slovakian origin and it is understood that he had come to England about 12 years previously. In Slovakia he had been in military or police service and latterly he had worked as a lorry driver. His understanding of English was limited and he relied on friends and professional interpreters to translate for him. On occasions interpreters advised that they could not understand what Anton said, which may have indicated that he also struggled with his speech, perhaps as a result of a stroke or dental problems.

Anton had significant health problems. It is alleged that a family member broke his jaw in 2012. In 2013, he had walked out in front of a car while intoxicated. In the following years he may have had as many as three strokes which prevented him from working. Certainly he had a stroke in 2018 which led to engagement with stroke rehabilitation and the Stroke Association. His poor diet also contributed to health problems and he may have had scurvy (caused by vitamin C deficiency) on occasions.

Anton had mental health concerns and struggled with anxiety but would not engage with Mental Health Services. Concerns were also expressed about possible Post Traumatic Stress Disorder and suicidality (prior to the review period). Throughout the IMRs, there are also references to problems with alcohol. However, it is unclear whether alcohol was still impacting on him in the last months of his life.

In 2017 he had a major problem with his benefits. He was mistakenly advised to go on to Universal Credit, but was then deemed to have failed the Habitual Residence Test and his Universal Credit was stopped. After eight months, this decision was reversed but, in the interim, the lack of money and stress involved may have impacted on his eating, his health, his mental health and possibly his trust in services.

In the last two years of his life, Anton was the subject of two safeguarding concerns. These raised questions about both self-neglect and possible financial abuse. The first of these safeguarding concerns was closed very swiftly. The second resulted in more intensive intervention but did not progress to an enquiry under Section 42 (2) of the Care Act.

It is unclear the extent to which Anton was being abused or exploited by others. The SAR Referral says: "There were a number of concerns in relation to Anton's capacity, self-neglect and *possible financial abuse"*. In 2012 the Police reported that he was assaulted by a family member and in 2020 there was an argument with a woman he knew, but there is no evidence that this was more than a bi-directional argument and no accusations were made by either party. In September 2020 the Police were called to criminal damage to his front door – but again there is no evidence that this was more than a random act of damage by a passer-by.

Concern was expressed that Anton may have been financially exploited by at least two separate women. Indeed, the use of his bank card by one of the women may have been continuing up until close to his death. His Money Advice Officer raised concerns around capacity and financial abuse in the safeguarding referral submitted to Adult Social Care in July 2021. This referral was accepted and allocated to a Social Worker.

By this point, his health was poor and he was reporting stomach pain and that he was unable to keep food down. As a result he was not eating properly and was neglecting his personal care and home environment. Towards the end of his life, Anton was reported to not have been leaving his property due to his health.

However, Anton struggled to sustain his independent living needs. His mobility appears to have been impaired and he would have stumbles and falls but would not contact professionals. This is believed to be due to fears of external involvement. Anton told professionals that he was unable to eat, and there was evidence that food provided was left untouched. It is believed that Anton did not consume any food from 13th October 2021 up until his death. His housing provider contacted Adult Social Care 17 times following the second safeguarding concern with regard to his wellbeing.

A significant feature of Anton's presentation is that he was often difficult to engage with services. In the review period, there are at least 15 examples of Anton not engaging with services or appointments as would have been expected. Most significantly, not attending surgery for suspected bowel cancer in September 2021. However, there are also other examples of Anton not attending appointments, not answering phone calls, not engaging with paramedics or discharging himself from hospital. There were a complex set of reasons behind this pattern including, for example, language, lack of trust in services and possibly other reasons such as pride.

Nonetheless, to many professionals he will have appeared to be “difficult to engage” and this will have added to the challenges of working with him.

As his physical health deteriorated, a Social Worker undertook a mental capacity assessment because Anton was showing signs of not understanding his financial situation. He was found to lack the mental capacity to manage his finances, however, the available evidence does not indicate what was put into place as a result of this assessment. No other mental capacity assessments were undertaken.

It appears that Anton was stuck in a very difficult ‘loop’. It was hoped that his mental wellbeing would improve if his physical health was addressed. Yet his anxieties and mistrust of Health Services, as well as the language barrier and the lack of support, were preventing his physical health problems being resolved.

Anton lived in a Housing Association property. He had previously been homeless, and was extremely fearful of losing his home. There were problems with the condition of the property which were initially not reported and once the issues were identified, Anton would not engage with the repairs. One professional described a visit to Anton during the winter in which his house felt colder indoors than it was outdoors.

He was allocated a Floating Support Worker to help him clear his flat so that repairs could be undertaken. He was also in the process of being supported to source alternative accommodation with a higher level of support. Both these processes were occurring at the time of his death.

In the final weeks of his life, he seems not to have been eating and is described as having drawn the curtains and being reluctant to allow people in. As a result of all these problems he was subject of a multi-agency meeting in October 2021. A further meeting was planned, but he died before it could happen.

By that time he was living in an appalling condition. His property was in a poor state of repair and professionals who saw it after his death described it as covered in mould with thick layers of dust on most surfaces. Multiple cupboards and drawers were stuffed with paperwork going back 15 years or more. Bed sheets appeared not to have been washed in months and were stained with urine and excrement.

Anton died of pneumonia in November 2021. He was found on the floor in the foetal position and was wearing a pair of yellow crocs that were filthy and covered in mould. He had engrained dirt under his finger nails, which appeared to show that he neglected his cleanliness and hygiene.

9. Chronology

A chronology of Anton’s involvement with services was compiled from the material in the IMRs. This has been used to support the findings of this document. It runs to 20-30 pages of text; therefore, it has not been included in this report for fear of making it unreadable. However, it is available via the SAB to partner bodies.

10. Overview of emerging themes

Anton was a man who presented some problems which were specific to him: his poor comprehension of English, his problems with the benefits system and some particular problems with responses from services. However, he shares features with many other people who require safeguarding: he was difficult to engage in services, there are possible problems with both his mental health and alcohol use and there are questions about the use of the mental capacity framework.

The central focus of this review is:

- What lessons can be learned from the steps taken to safeguard and protect Anton?

However, this question breaks down into a number of themes including:

- Safeguarding practice
- Mental capacity
- Inappropriate responses from services (e.g. failed service provision and short term working)
- Working with difficult to engage clients
- Multi-agency management
- Problems with benefits payments
- Working with people with limited English and poor communication skills
- The identification of possible alcohol use disorders
- The impact of Covid-19 restrictions

This review splits these themes into two sections: those which are more specific to Anton and his situation (section 11) i.e. the connected themes of his problems with the benefits system, the response from services and the issues caused by his poor English language skills. The second section (section 12) explores more generalisable themes around engagement, safeguarding, mental capacity, multi-agency management, alcohol use disorders and Covid-19.

This review highlights points at which Anton would have benefited from different responses from services. However, he also benefited from some very intensive and high quality work from some agencies e.g. his Housing Provider. This is reflected at points in the review and in the Good Practice section at the end.

11. Benefits, language and service responses

11.1 The problems with his benefits payments

Anton had significant problems with his benefits. This was mostly prior to the period under review but was seen by professionals as having an ongoing impact on his health and well-being. In 2017, Anton was mistakenly advised to come off disability benefit and move onto Universal Credit. However, he was then found to have failed the Habitual Residence Test and his Universal Credit was stopped. He was referred to

Citizens Advice Bureau (CAB) supported by Mental Health Reablement. CAB advised he was not entitled to state benefits and would need to find employment.

For many months, Anton was at threat of becoming homeless and was not eating well due to the loss of his benefits. Ultimately, with praiseworthy support from his Housing Association staff, this decision was reversed but it does seem to have caused Anton considerable anxiety. It may have contributed to his health problems and may have led to anxiety about his financial situation that could have impacted on some of his later behaviours.

Anton was the "victim" of a very complex area of legislation complicated further by Anton not understanding much of the information provided in English. It is likely that an analysis by a benefits expert may identify some more specific lessons to be learned from Anton's situation. However, that cannot be the purpose of this SAR.

More simply, the Practitioners' Workshop felt that the problems lay in professionals not understanding this complex area of benefits legislation. At its simplest the Workshop highlighted the need for either more training or easier access to expert support on supporting foreign nationals through the benefits system.

11.2 Hearing his voice - Language and culture issues

Anton primarily spoke Slovakian. The degree to which he could understand and communicate in English is a matter for debate. He clearly had only very limited English but at times – e.g. incidents with the Police in May and September 2020 he appears to communicate in basic English. That does not mean that he found it easy or that he did not need help.

The response to this challenge varied. In some cases there was very good practice. The Ambulance Service used a telephone translation service to communicate with him (which seemed to work well). The Mental Health Trust was sensitive to the fact that Anton struggled with the English language and, both times practitioners encountered him, they ensured he was able to use Slovakian to communicate. Above all, his housing provider always attempted to engage an interpreter to ensure that they could fully understand Anton's wishes and feelings.

However, practice did not always meet this standard. The Police acknowledge that in 2018 (prior to the review period) Anton called Police asking for help and asked Officers to remove a woman from his address. The Officer attempted to use Language Line but when this was not possible, Police left it up to Anton to initiate contact and attend at the Police station at his discretion. Anton did not attend i.e. calling back with an interpreter to explore any issues. On the other hand, it should be noted that Anton was able and willing to call the Police and ask for help as he did on this occasion.

Adult Social Care arranged interpreters for home visits to ensure he was able to understand and express his views effectively. However, on one occasion a Social Worker contacted Anton via phone to check his wellbeing, but it just went to voicemail and a message was left in English with contact details. It appears there was no

realisation that Anton may not understand this message despite the practitioner knowing that there were communication difficulties. There was no further follow up to ensure he was safe and well and to offer further assessment.

More crucially Anton had particular problems engaging with Health Services, both Hospital and Primary Care, because letters and texts were sent to him in English and Anton did not understand correspondence received in English. Anton did not attend an appointment at the general hospital due to the letter being in English.

In particular, the benefits appeal process that Anton had to go through from 2017 was particularly challenging as all the letters were in English. It was noted at that time he had a large pile of unread letters in English at his home address and evidence from the IMRs highlights the complexity of the benefit system for a person who does not speak English.

Other factors may have impacted on Anton's ability to communicate. The strokes that he had and the loss of his teeth may also have hampered communication. Even one of the interpreters commented that due to slurred speech, it was not possible to understand some of what Anton said.

In terms of the wider issue of Anton's culture and identity, good practice was evident in that he was matched with a Slovakian volunteer for support during 2020. It is unclear on the notes if this was successful or if she linked him to any other Slovakian community members. It is also known that a Polish speaking volunteer collected prescriptions for him and did his shopping, their conversations were limited because although the two languages are closely related, they are not identical.

There were also concerns raised at the multi-agency meeting in October 2021 that the food provided to Anton was not culturally appropriate. It is unclear whether this was a significant problem.

This raises the question of whether Anton's voice was fully heard. The Adult Social Care IMR comments that: *"It is evident on the notes that his views and wishes were sought but one cannot confirm they were understood completely by the professionals involved as it is apparent that Anton's concerns were not resolved."* This is probably a fair reflection of the position of other agencies. His housing provider made real efforts to access translation services and understand his views. Other agencies were making similar efforts to hear his voice. However, the nature of his death suggests that agencies had not been able to engage Anton in ways which helped him to move forward.

11.3 The response from services

Anton did receive some very positive responses from local services. For example, the Money Advice Team offered a high level of support in relation to his settled status and benefits. His Housing Association referred Anton to a local service offering floating support. His housing provider made welfare calls to Anton during the pandemic – one of a programme of calls to more vulnerable individuals to offer additional support. These welfare calls resulted in referrals to: emergency services,

Adult Social Care and a voluntary support service. Ultimately a multi-agency meeting was set up and led to actions such as the allocated Social Worker speaking to the GP about a visit from a dietitian.

However, there were also gaps in services' responses. (This review has already identified problems in the care of Anton as a result of language barriers.)

In 2021, Anton was assessed to have eligible care and support needs under the Care Act by his allocated Social Worker. A referral was made to the Mental Health Reablement Team to consider support at home; but the referral was rejected due to lack of availability. However, there does not appear to have been any further follow up by the Social Worker to source alternative care and support for Anton. The Social Worker had seen Anton several times at home with an interpreter present; however, further support at home had not been considered in between the rejection of the reablement referral and his death.

Given his declining health in the autumn of 2021 and the nature of his death, the adequacy of the response to his poor physical health has to be considered. During the review period Anton himself failed to attend various appointments including key pre-operative hospital appointments and this undoubtedly impacted on his health. Covid-19 restrictions may also have made it harder for health agencies to engage with him.

More particularly, in the last two months of his life, repeated concerns about Anton not eating and his deteriorating physical health were raised with the Social Worker and then via the Social Worker to the GP. The Social Worker contacted the Practice three times in September before a consultation was arranged with Anton. This was a telephone consultation which was unsuccessful because of communication problems. As a result a home visit took place in early October.

The home visit was inconclusive because Anton was ambivalent about his treatment options. However, there was a difference in perception about the next steps. Anton and the Social Worker appear to believe that the GP would come back to Anton once he had had time to think over his options. The GP appears to believe that Anton would initiate further contact.

After this visit, the Social Worker twice followed the case up with the GP seeking a follow-up home visit, the second of these calls resulted in an invitation for Anton to attend the surgery – which he did not do. The GP and the Social Worker had a discussion at the end of October about next steps, in which the GP acknowledged a lack of response due to home working. However, this meeting did not result in a home visit and Anton died before any further action could be taken.

There are four occasions in this period where contacts from the Social Worker about Anton are not recorded in the Primary Care notes. This has been acknowledged by the Practice and is being treated as a significant event.

Other gaps in the response from service include:

- Housing Association operatives attempted to attend Anton's property to carry out the job but were unable to make contact with Anton. However, the inability to complete the job was not shared so that it could be rearranged.
- There appears to be a delay between a Social Worker's home visit and contacting the GP to request follow up.
- Anton was not picked up by IAPT due to a technical error on a referral. This was not identified until 3 months later.

It is possible to argue that Anton was simply "unlucky" in his engagement with services. It is also possible that Covid restrictions impacted on his care (see below). However, it is also possible that the challenge of working with someone with poor English and other communication problems had an impact as mentioned above. It is also likely that because Anton was often reluctant to engage with services this also impacted on the response he received from services – this is explored below.

The Police IMR raises the important issue of the need for professional curiosity. It states that *"Officers should use professional curiosity when dealing with adults, to ascertain if they are struggling with alcohol or mental health. This is a reoccurring message which Cheshire Police are continually pushing on force newsletters and training."*

This message applies to other services involved with Anton. Both health and social care could have used more professional curiosity to understand what was happening with Anton in terms of his health, his diet, his relationships, his involvement with care and the state of his home environment.

This review cannot say for certain why there were these shortfalls in service response, but it is important that service providers review the identified problems and consider whether they would occur again with other individuals.

12. Engagement, safeguarding, mental capacity, multi-agency management and alcohol use disorders

12.1 Engagement

The most practical challenge with Anton was that he was very difficult to engage constructively in interventions. Anton had frequent contacts with some services but would not always follow through on steps that would help him, especially with services in the healthcare system: he failed to attend appointments, discharged himself prematurely from care or refused to engage with paramedics. This made it difficult to undertake the support that would have been required to reduce his risk and stabilise his situation.

It is easy to see these engagement challenges as a *client failure* and an indicator of a lack of need for services. For example, one of the IMRs comments: *Due to the increasing agitation, the non-engagement, and the professional opinion that he could manage, calls were ceased.* Professionals should consider carefully whether non-

engagement is, in reality, an indicator of someone who is struggling and needs more assertive intervention.

This raises questions about themes such as escalation, multiagency management and mental capacity which are explored elsewhere in this review. However, at its most basic, it raises questions about ensuring that professionals have clear guidance and training on how to respond to individuals who are difficult to engage in services.

A central recommendation of this review is the need for a procedure to guide professionals in dealing with client non-engagement. Anton's case history highlights that to make that procedure useful it will need to provide guidance on:

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

The Adult Social Care IMR comments that: *It would be beneficial if the SAB could undertake some work around guidance when individuals do not engage with support and non-attendance at appointments...*

This process, whether single agency or multi-agency, would also benefit from guidance on what techniques work with hard to engage clients. This is an under-developed field. The SAR author looked for national guidance on this issue as part of the drafting of this report but could not find an overarching guidance document. Reports such as "The Keys to Engagement" (mental health)[1] and "The Blue Light Project" (alcohol misuse)[2] have addressed this issue with specific client groups but there is no single guidance document. Whether this is at a local or a national level, such guidance will be a vital support to those working with vulnerable and difficult to engage clients.

(It should be noted that the national SAB Manager Network is currently developing guidance on working with difficult to engage clients. This is not complete but may fill this gap.)

12.2 Safeguarding / Adult Social Care

Faced with Anton's pattern of vulnerability and self-neglect, the key question is whether the appropriate steps were taken to address these needs. Two safeguarding referrals were made during the review period. Anton was also subject to a Police concern for safety in April 2016. This led to a referral to Alcohol Services which, it is presumed, was not pursued by Anton.

In June 2019, there was an adult needs assessment completed by a Social Worker which identified that he had eligible needs in five outcomes with a next step of involving reablement to assess his long term needs. This was closed in July 2019 after a review

[1] https://www.centreformentalhealth.org.uk/sites/default/files/keys_to_engagement.pdf

[2] https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project

concluded that there were no eligible needs *due to there being no significant impact on wellbeing if outcomes were not achieved*. It is hard to evaluate the appropriateness of this decision in retrospect, but it appears hard to reconcile with what subsequently occurred.

During the review period safeguarding concerns were raised in April 2020 and July 2021. The Housing Association's IMR suggests that their service should have also made a referral slightly earlier in 2020; but this would still have been in April 2020. In February 2021 there was a possible missed opportunity to submit a safeguarding referral when a Housing Association Worker had a conversation with an informal supporter who expressed concerns about Anton not eating properly and about his physical and mental health generally. The Housing Association have acknowledged that a safeguarding concern should have been raised. Just a few days later a Housing Association Building Surveyor recorded the poor state of Anton's home. This represented another opportunity to submit a safeguarding concern. In May 2021 another opportunity was identified to escalate concerns about his situation to Adult Social Care.

The April 2020 referral was made by the Ambulance Service following a face to face contact with Anton which was prompted by concerns from his housing provider. The paramedics had problems communicating with Anton and used a phone translation service to communicate. The translator had stated that Anton had no medication or food. The paramedics themselves found food and medication in the house but identified that Anton's property was unkempt. Anton told the attending crew that he had leg pain from an operation one month previously. The leg wound was checked and there were no signs of infection, and the wound was clean. Anton refused a hospital admission; but a safeguarding concern was raised.

As a result a Social Worker rang the Housing Association and clarified that the Ambulance crew had been out and checked his health. The view was that Anton required social support and there was a discussion about food parcels and community support. The Social Worker rang Anton but there was no answer. The Social Worker then rang the Local Area Co-ordinator and Anton was matched with a Slovakian volunteer to support with shopping and medication collections. Therefore, the safeguarding contact was closed at contact stage as it was decided that no safeguarding issues were indicated by the information gathered.

The notes are unclear, but the Ambulance Service may also have asked for a Section 9 assessment of Anton's care and support needs. This did not happen. The last time such an assessment that had been completed was July 2019. Therefore, an assessment would have been useful in exploring whether anything had changed within that year, if there were any issues with self-neglect or risks to his wellbeing.

There are no further notes to indicate the outcomes of the planned services. For example, information via the volunteer could have given a picture of how Anton was managing, his views and wishes and if he wanted further support from a Social Worker. It is fair to note that this process was at the height of the Covid-19 restrictions and this is likely to have impacted on the steps and decisions taken.

The second safeguarding concern was raised in July 2021 by his housing provider, as a result of concerns about financial abuse and his welfare. This safeguarding concern was not progressed to a S42(2) enquiry which would have been in line with the local safeguarding policy. As there was an allegation of financial abuse as well as concerns about his welfare and previous history of non-engagement Anton appeared to meet the criteria to progress to an enquiry. The Adult Social Care IMR highlights that this safeguarding should have followed the SAB complex safeguarding policy.

The case was closed to safeguarding; however, a Social Worker was allocated and worked with Anton until he died. Nonetheless, his housing provider shared informal safeguarding concerns with Anton's allocated Social Worker via email and over the phone 17 times from 14/07/2021to 02/11/2021. They also shared concerns about possible financial abuse with the DWP Safeguarding Lead in September 2021.

This process highlights the importance of submitting safeguarding concerns as a means of focusing attention on complex and vulnerable clients. If concerns had been raised more frequently, Anton's needs would probably have been escalated to a Section 42 (2) inquiry and he might have benefited from multi-agency review.

The Adult Social Care IMR does highlight good practice in response to this safeguarding concern. There was one Social Worker involved throughout the process. This Social Worker completed home visits and used the interpreter. The Social Worker completed a Care Act assessment and a mental capacity assessment regarding finances when he had doubts about Anton's ability to understand and weigh up decisions about his finances. The Social Worker did complete steps to look at an appointeeship to reduce Anton's future risk. Steps were taken to provide support packages, explore alternative accommodation, look at maintenance to the property, and make a GP referral about alcohol misuse and health concerns.

However, the Adult Social Care IMR recognises that there were delays, and some opportunities were missed:

- The notes show evidence that finances were discussed with reference to looking at bank statements for withdrawals, but one cannot see professional decision making in terms of risk regarding the financial abuse allegation.
- Although his assessment determined he had eligible needs, it appears a timely support plan was not put in place to meet those needs.
- Meals were started in September but then cancelled and the notes indicate these ceased within three weeks due to non-payment yet observations in September was that he was very thin. Anton had wanted them to continue but it is unclear why these had not re-started. This does highlight that practitioners need to have the confidence to ask about waiving charges where a vulnerable person is in crisis and in a safeguarding situation.
- Contact with the GP could have been acted on sooner when health issues were observed during visits in July. One could query that if Anton was so unwell in October and it was impacting significantly on his cognition and his physical wellbeing, could there have been more support to get him to hospital?
- There is no evidence of any multi-agency risk assessment and risk management plan. Neither is there an individual agency risk assessment on

file. This is a gap especially with Anton's previous non engagement with support.
- Anton should have been referred to the high risk/complex safeguarding forum as per Safeguarding Adults Board Policy.
- Anton's housing provider was not provided with a copy of a safeguarding plan.
- More follow up was required with the GP regarding alcohol and mental health concerns and a possible referral to a Community Matron for health issues.

The Adult Social Care IMR summarises the situation: *it is not evident on the case file that a safeguarding adults plan, separate risk assessment or care and support plan were completed. The Care Act assessment in August 2021 does, however, evidence that there is risk of self-neglect, abuse from others and risk of harm to property and that there would be a significant risk to his wellbeing if his outcomes were not met... factors present that may have delayed support plans being implemented, include the impact of covid-19 and lack of availability for reablement.*

12.3 Multi-agency management / escalation

Multi-agency management was limited in the care of Anton. The Adult Social Care IMR comments that: *There were missed opportunities for all the professionals involved to meet via multi-agency forums on TEAMS.*

Ultimately, a Money Advice Officer set up a multi-agency meeting in October 2021 to discuss the ongoing safeguarding concerns and the deterioration in Anton's health and wellbeing. This meeting involved a Floating Support service manager, Social Worker, a Safeguarding Officer at his housing provider and a GP. At the meeting financial abuse, self-neglect, urgent physical health needs and mental capacity were discussed. A professional's plan was devised as a result of this meeting. A second meeting was planned for November 2021 but did not happen due to his death. References are made in the IMRs to other meetings but it has not been possible to identify when or if these occurred. It seems certain that no other comprehensive multi-agency meeting occurred.

Multi-agency management is one form of escalation. Another would have been the involvement of more senior management. There appears to be a lack of senior manager involvement from November 2019 onwards. If the safeguarding had been progressed and referred to complex safeguarding, then senior management would have been involved. Similar concerns about the lack of senior manager involvement are expressed by his housing provider: *Internal escalation should have taken place after the safeguarding referral was submitted on 08/07/2021 due to the lack of support and action from Adult Social Care and Health. External escalation processes should have been followed to ensure that relevant services were fully engaged specifically Adult Social Care and GP.*

At practitioner level, however, there is evidence of joint working. There was regular communication via email and over the phone, between July and November 2021 between his Money Advice Officer (MAO), Social Worker and Floating Support Officer. The MAO also provided updates to the DWP safeguarding lead in relation to the concerns around possible financial abuse, settled status and the capacity assessment

that the allocated Social Worker was due to complete. Staff at Anton's housing provider had telephone and email communication with the allocated Social Worker and the Floating Support Worker. The housing provider conducted joint visits with the Social Worker and the Floating Support Worker on two occasions in September 2021.

Nonetheless, it is likely that Anton would have benefited from escalation to either a multi-agency framework or some other senior management group and this did not happen early enough for it to have an impact on his care.

12.4 Mental capacity

Anton's care raises questions about the use and impact of the Mental Capacity framework. Anton appeared to be making a series of decisions which impacted very negatively on his health, his finances, his housing and his general well-being and which may well have contributed to his death. This must raise questions about whether Anton had the mental capacity to take these decisions.

Anton may also raise questions about the challenge of assessing capacity with someone who has only limited English and comes from a different cultural background. In particular, where his poor English language skills may conceal other communication difficulties. However, these challenges were not specifically identified or commented on in the IMRs.

The original SAR referral raised concerns about Anton's capacity and his ability to meet his own care needs. In March 2019 (prior to the review period) Anton was taken to hospital due to suicidal ideation. At hospital Anton denied this and declined assessment and it was felt he had capacity to make this decision and was discharged.

In January 2020 an ambulance was called to Anton because of a collapse the day before. He refused transport and the Paramedics documented him to have capacity. In March 2020, a Social Worker was planning to assist Anton to move to a care home for assessment, but he refused. The Social Worker felt Anton had no mental capacity concerns and he had made an "unwise decision".

In October 2021, Anton's GP completed a home visit with an interpreter. They discussed falls and recent issues with bowels and stomach pain. The GP agreed to allow time for Anton to think about his options and whether he would like to go ahead with further surgery. The GP documented that Anton had capacity to make this decision.

The Safeguarding Referral in July 2021 raised concerns around capacity and financial abuse, particularly because he was about to receive a large benefits arrears payment. A mental capacity assessment was undertaken by his Social Worker around finances in October 2021; concerns were expressed that Anton did not have the ability to weigh up the risks and consequences of decisions he made and the ability to execute decisions regarding finances. However, no other mental capacity assessments were completed for other areas such as care and support planning.

The condition in which he existed for the last months of his life must raise questions about whether he really had the capacity to care for himself and take decisions that maintained his health. Therefore, the question is why was this not more actively considered by key professionals.

The answer to this can only be speculation but three themes may be relevant:

- Professionals placing an emphasis on people's "right to make unwise decisions" to a degree which is out of step with the Act.
- Professionals not considering executive function and executive capacity.
- Professionals not understanding the need to continue to take steps with people who do have capacity but nonetheless make unwise decisions.

Anton was an individual who would often reject or disengage from services. As one provider said: *"He didn't want support from us he wanted to be left alone."* Faced with such attitudes it is easy for workers to assert someone's "right to make unwise decisions". However, the Act does not make a blanket statement that people have a right to make unwise decisions. They have that right if they have the mental capacity to make that decision. At times, this important caveat can become lost in workers' thinking.

The report of '*The 2013 Mental Capacity Act 2005: Post-Legislative Scrutiny*', specifically highlighted the challenges posed by clients like Anton: *The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases, this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult.* [i] *…Such points were echoed in the submissions from family carers who expressed frustration at the misappropriation of the assumption of capacity by health and social care staff to justify poor care.* [ii]

In assessing capacity with vulnerable and self-neglecting individuals like Anton it is important to consider executive function. The Teeswide Carol SAR talks about the need to look at someone's "executive capacity" as well as their "decisional capacity". Can someone both *take* a decision and *put it into effect* (i.e. use the information)? This will necessitate a longer-term view when assessing capacity with someone like Anton. Repeated refusals of care should raise questions about the ability to execute decisions. The draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function and to consider repeated failed decisions when assessing capacity.

Even if it was decided that Anton did not lack the capacity to care for himself, professionals may still need to help him to make decisions about his care. The MCA Code of Practice repeatedly highlights the need to assist capacitous people with their decision making e.g. *people must be given all appropriate help and support to enable them to make their own decisions*[iii]*; it is important to take all possible steps to try to help them reach a decision* [iv]*; it is important to provide appropriate advice and information*[v]*; providing relevant information is essential in all decision-making.* [vi]

Perhaps more relevantly the Code of Practice comments that:

2.11 There may be cause for concern if somebody:
• repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or
• makes a particular unwise decision that is obviously irrational or out of character.
These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation…[vii]

Far more consideration could have been given to how the Mental Capacity Act was used with Anton. Ultimately, consideration could even have been given to building a case for action under e.g. Article 2 of the Human Rights Act 1998.[viii]

12.5 Alcohol use disorders

The picture of the role that alcohol played in his life is very unclear. In the evidence from the Police there are reports of intoxication: Anton was seen on multiple occasions by Police between 2012-2016 drunk and struggling to communicate. This is the period in which he was knocked down by a car while intoxicated. In 2016 he was also referred to Alcohol Services: it is assumed (although not known) that nothing came of this referral. His Adult Social Care Assessment in 2019 expressed concerns about alcohol misuse but involvement with Adult Social Care was closed.

However, in the period under review, evidence about his use of alcohol is much less clear cut. For example, in the last days of his life, his GP felt that he was drinking alcohol but Anton denied this. A Housing Worker, who knew him well in this period reported that she had not seen him drunk on any of her visits. It is, therefore, not possible to say what role alcohol played in his self-neglect and death.

At the very least, this is a reminder of the importance of robust alcohol screening processes to ensure that any alcohol-related risk is identified and highlighted. In accordance with NICE Public Health Guidance 24, professionals working with the public need to be alert to the possibility of alcohol use disorders and should be routinely asking the AUDIT questions and using professional curiosity to explore this issue. Best practice would ensure that the AUDIT alcohol screening tool[ix] is routinely being used by all relevant professionals, whether in Primary Care, Mental Health Services, Adult Social Care, Housing or any other adult service.

13. Covid 19

The majority of the period under review was during the Covid-19 restrictions. The IMRs have mixed views on whether these restrictions impacted on his care. The Police and, more importantly, the Floating Support Service did not feel that this had had an impact.

However, other IMRs recognise that responses from Adult Social Care, the GP and the Hospital may have been affected by Covid-19. Anton's housing provider felt that there was less opportunity to see Anton face to face. Adult Social Care recognise that Anton: *"was not seen face to face/ or assessed and one could conclude this was*

because it was at the height of the pandemic. Lack of availability of care and support is also another significant factor impacted by Covid. It was also noted by the Social Worker that a slow response from the GP was due to the fact the GP had been home working." His physical healthcare may also have been impacted, e.g. keeping virtual clinic appointments rather than face to face appointments.

However, it is probably unreasonable to draw any conclusions about services generally from provision during this unique period. Therefore, this theme does not feature in the learning and recommendations.

14. Key Learning Points

Any comments on the learning from Anton's care need to be prefaced by a recognition that most of the period under review was at the height of the Covid-19 restrictions. This may have impacted on the interventions that he received and this needs to be acknowledged when reading these comments.

It should also be noted that there was good, assertive practice with Anton. Certainly in the last months of his life, many agencies were aware of his vulnerability and were taking steps to address this. Nonetheless there is important learning from the circumstances of Anton's death. Anton posed some very specific and individual challenges to services. But his care also provides messages that are relevant to work with many vulnerable and difficult to engage individuals.

The features which are more specific to Anton are his loss of settled status and consequent loss of benefits, his language skills and some problems with individual services.

Anton's care highlights the need for relevant professionals to have either more training or easier access to expert guidance on supporting foreign nationals through the benefits system. At a more nuanced level it shows the impact that loss of benefits can have on an individual. In Anton's case, it is arguable that this experience impacted on many of his subsequent interactions with services.

Although many agencies worked effectively to overcome Anton's language barriers, not all agencies recognised the problems posed by his lack of English and messages and letters were still being sent in English at points near to the end of his life. This is not a general statement that all migrants who lack English language skills should receive all messages and calls in their native language, but when dealing with complex and vulnerable individuals this is clearly going to be a necessity.

Anton experienced a number of gaps in the service he received from various agencies. For example, the lack of follow up after the rejection of the Mental Health Reablement Service referral or the error with the IAPT referral. These appear to be very individual problems and have been recognised by the services involved. As a result no recommendations have been made about them.

Aspects of the Primary Care response to Anton, particularly in the last two months of his life have been acknowledged to require review e.g. the recording of telephone

contacts. However, this response may suggest a wider need to review the way in which Primary Care responds to chaotic and vulnerable individuals who are hard to engage in standard Primary Care appointment systems.

More generally, the key point is the need to think carefully about how agencies work with clients who are difficult to engage. The Adult Social Care IMR comments that: *It would be beneficial if the SAB could undertake some work around guidance when individuals do not engage with support and non-attendance at appointments...*

This review agrees that the response to difficult to engage clients will be strengthened by the development of a local policy or procedure which guides professionals on how to work with such clients. It should include comment on the level of risk that requires a more assertive approach and identify the need to escalate the more vulnerable, hard to engage clients, to a local multi-agency forum for joint management.

Anton's care would certainly have benefited from more multi-agency management and escalation to senior staff or groups. The only identifiable multi-agency meeting was held in the month before he died. It was acknowledged in at least one of the IMRs that professionals should be using such approaches with this client group.

At the heart of this is mental capacity. Professionals only ever assessed Anton's capacity to manage his finances. However, other issues could have been considered, e.g. was Anton able to care for himself and maintain his health? It is not clear why these assessments were not happening in a timely manner but it does raise questions about whether:

- Professionals place too great an emphasis on people's "right to make unwise decisions".
- Professionals are considering executive function and executive capacity.
- Professionals are not understanding the need to take steps with people who have capacity but nonetheless make unwise decisions.

Therefore, Anton's care raises questions about training on the use of the Mental Capacity Act with vulnerable individuals, including training around executive function / capacity. However, it also highlights the importance of not seeing "having capacity" as an end to the need to make efforts to help people with their decision-making. This has been clearly stated in both the original and draft Codes of Practice to the Act.

Two safeguarding referrals were made during the review period. The first of these was closed very swiftly. The second did not progress to a S42(2) enquiry in line with the local safeguarding policy. However, social care involvement did continue up until Anton's death. It is possible that further safeguarding concerns should have been raised at other points in the two year period.

It has been acknowledged by the Adult Social Care IMR that Anton should have received a more intensive safeguarding response. It has also been suggested that Covid 19 restrictions may have impacted on the response he received.

However, this does suggest the need for ongoing training about the need to raise safeguarding concerns about vulnerable individuals and that within Adult Social Care practitioners are:

- Able to identify self-neglect concerns through effective triage and understand when those concerns require a safeguarding enquiry s42(2).
- Familiar with the complex safeguarding policy, agency's escalation policies and the need for multi-agency meetings to share information and risk

Anton may have had a history or pattern of alcohol use disorders. The challenge is that there was a lack of a detailed understanding of the nature of his use. This highlights the importance of standardised screening tools. In particular, following NICE Public Health Guidance 24, the AUDIT alcohol screening tool should be widely used by all frontline professionals to provide a consistent means of communicating information about alcohol-related harm.

15. Good practice

Some agencies and individual professionals made significant efforts to engage with Anton and to improve the quality of his life. In particular professionals from his Housing Association and Floating Support service made assertive efforts in the last year of his life to engage with him and secure the help that he needed. Before that, and largely before the review period, his Housing Association's Money Advice Officer had made highly praiseworthy efforts to resolve the problems he experienced with the loss of his settled status and the right to benefits.

Anton had problems communicating in English and although there were problems around this, many agencies e.g. his Housing Association, Floating Support Service and Ambulance Service, actively used translation services and other agencies including Primary Care and the Hospital were coming to the recognition of this need. He was matched at one point with a Slovakian volunteer from a local service. Again outside the review period Mental Health Reablement identified a Polish Reablement Worker to support him because of similarities between the two languages.

16. Recommendations

Recommendation 1 – The Cheshire East SAB should reassure itself that there is training or access to expert support on supporting vulnerable foreign nationals through the benefits system.

Recommendation 2 – The Cheshire East SAB should reassure itself that all agencies are considering the use of translation services and providing materials in native languages for vulnerable individuals who are not English speakers.

Recommendation 3 – The Cheshire East SAB should lead the development of local procedures that guide professionals on how to respond to individuals requiring safeguarding but who are hard to engage. (These protocols could equally apply to vulnerable clients outside of the safeguarding context).

Recommendation 4 – The Cheshire East SAB should ensure that those procedures include a structure for determining the level of vulnerability associated with a client, which will then guide the level of persistence that is used to follow-up these clients.

Recommendation 5 – The Cheshire East SAB should ensure that those procedures include the need to escalate the more vulnerable, hard to engage clients, to a local multi-agency forum for joint management. The SAB should ensure that the importance of escalating concerns about more vulnerable clients to multi-agency agency management frameworks is cascaded as widely as possible through their own and partner agency communication systems.

Recommendation 6 – Alongside the procedures, the Cheshire East SAB should consider the development of more practical multi-agency guidance on “What works with hard to engage clients”, including, for example, continuity of care.

Recommendation 7 - Cheshire and Merseyside Integrated Care Board should review the way in which the healthcare system across both Primary and Secondary Care responds to chaotic and vulnerable individuals who are hard to engage in standard appointment systems.

Recommendation 8 – The Cheshire East SAB should ensure that guidance or protocols are available to support professionals to consider the use of the Mental Capacity Act in the context of difficult to engage clients. This should include reminders about the importance of considering executive capacity and that people with capacity may still need ongoing help with their decision-making.

Recommendation 9 – The Cheshire East SAB should ensure that there is ongoing training and messaging about the need to raise safeguarding concerns about vulnerable individuals and that, within Adult Social Care, practitioners are:

- Able to identify self-neglect concerns through effective triage and recognise when those concerns require a safeguarding enquiry s42(2)
- familiar with the complex safeguarding policy, agency’s escalation policies and the need for multi-agency meetings to share information and risk

Recommendation 10 - Cheshire East's Public Health Team should ensure that all frontline services are aware of, and are able to use, robust alcohol and drug screening tools such as the AUDIT tool to identify and record the level of substance related risk for clients.

Appendix 1 - Terms of reference for Anton SAR

- Did your agency have any information to suggest that Anton was being abused, neglected or self-neglecting? If so, was this information appropriately acted upon? Was work in the case consistent with agency and SAB policy and procedures for protecting adults at risk and other relevant local policies and procedures?
- What were the key points or opportunities for risk assessment and decision making in this case in relation to Anton? Do the assessments and decisions appear to have been reached in an informed and professional way?
- Does it appear that all legal options, including seeking legal advice where appropriate, were explored to safeguard Anton?
- Where relevant, were appropriate Safeguarding Adults Plans (protection plans), risk assessments or care plans in place and were these plans implemented? Were there any factors present that prevented these plans being implemented successfully? Had review processes been complied with?
- When, and in what way, were Anton or her family's wishes, feelings and views ascertained, considered and acted upon? Did action accord with the views expressed?
- Was practice sensitive to any protected characteristics of Anton?
- Was the person's voice sought, heard and understood?
- Were senior managers, or other agencies and professionals, involved at points where they could have been?
- What are the lessons from this case for the way in which your agency works to protect adults at risk and promote their welfare?
- Are there any aspects of SAB policy and procedures that need to be reviewed as a result of this case?
- How well was the person's culture and identity identified and responded to?
- Were appropriate steps taken to address hoarding, self-neglect, substance misuse and mental health?
- To what extent was there a persistent, creative, and flexible outreach approach to working with Anton?
- Were appropriate steps taken to address any housing / homelessness issues?
- To what extent did consistent multi-agency management feature in his care?
- Was the potential impact of his physical health status on his mental well-being considered including head injuries, smoking, diet, nutritional status and weight?
- Are there any aspects of the case or agency involvement that are examples of strong practice?
- Did Covid-19 and the accompanying social restrictions impact on his care?

[i] Mental Capacity Act 2005: Post-Legislative Scrutiny 2013 page 105
[ii] Mental Capacity Act 2005: Post-Legislative Scrutiny 2013 page 64
[iii] Mental Capacity Act 2005: *Code of Practice 1.2*
[iv] Mental Capacity Act 2005: *Code of Practice 2*
[v] Mental Capacity Act 2005: *Code of Practice 2.8*
[vi] Mental Capacity Act 2005: *Code of Practice* 3.7
[vii] Mental Capacity Act 2005: *Code of Practice 2.11*

[viii] Department for Constitutional Affairs - A Guide to the Human Rights Act 1998: Third Edition – 2006: https://webarchive.nationalarchives.gov.uk/+/http:/www.dca.gov.uk/peoples-rights/human-rights/pdf/act-studyguide.pdf

[ix] Alcohol Use Disorders Identification Test (AUDIT) (auditscreen.org)