# Barking and Dagenham Safeguarding Adults Board


# Safeguarding Adult Review – Jack

Overview Report of a statutory Safeguarding Adult Review under s44 Care Act 2014 commissioned by the Barking & Dagenham Safeguarding Adult Board

## Independent Reviewer
## Mike Ward

## November 2022

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## 1. Introduction

Jack was 32 years old when he completed suicide by hanging. He was a white British male. Throughout his adult life he had patterns of anxiety and depression, suicidality, substance misuse and relationship problems. He was unemployed and, at the time of his death, he lived alone. His brother also completed suicide in the period prior to Jack's death. However, he does appear to have had a supportive mother.

The circumstances of Jack's death were referred to the Barking and Dagenham Safeguarding Adult Board (SAB) for consideration as a Safeguarding Adult Review (SAR) by North East London NHS Foundation Trust. The SAR Referral Panel 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 examined a period from January 2019 until Jack's death in January 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 Jack during this period. Agencies were also invited to include any other information they considered relevant outside the time period. The multi-agency panel commissioned an independent author to complete the review.

## 2. Purpose of the Safeguarding Adults Review

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.

## 3. Independent Review

Mike Ward was commissioned to write the overview report. He has been the author of ten safeguarding adult reviews 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
- An Independent Management Report from each agency involved

The following agencies were involved in the process:

- Police
- North East London NHS Foundation Trust
- Barking, Havering and **Redbridge** University Hospitals NHS Trust
- Adult Social Care
- London Ambulance Service
- GP / Primary Care

An initial SAR Panel meeting was held in March 2022 to discuss the process and timeline of the review. A Practitioner Reflection Day was held on 4th July 2022 and contributed a range of thoughts and views on Jack and his care.

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

## 5. A specific challenge

The author faced a specific challenge in writing this review. No-one he spoke to had ever physically met Jack and only one interviewee had even spoken to Jack. The practitioners' event was particularly hampered by the fact that no-one involved knew Jack beyond their agency's notes. This has made it difficult to both achieve a more rounded picture of Jack and to check the accuracy of some information. This needs to be borne in mind when reading this report.

## 6. Family contact

An important element of a SAR process is contact with family. Jack was in active contact with his mother who appears to have been a positive support. No other positive supports have been identified. He had a brother (or stepbrother) who completed suicide during the review period but nothing more is known about this relationship other than that Jack was upset by the loss. He also had identifiable relationships with two women both of which were characterised by abusive behaviour by Jack.

Efforts were made to contact Jack's mother but she did not respond. This was also the case with the Mental Health Trust's Serious Incident report and although she spoke to Jack's Mental Health Trust worker after the suicide, she declined the offer to speak to a manager.

## 7. Parallel processes

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

## 8. 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 report because the review process opened up new learning about the themes to be prioritised and how that material should be presented.

## 9. Background and personal Information

Jack was 32 years old when he died in his flat in January 2021. A Coroner's Inquest was held in November 2021 and concluded the death was suicide by hanging. He was unemployed at the time and was receiving benefits.

The author only spoke to one person who had talked to Jack, but this worker said that if you spoke to him on a good day, he could be very nice and quiet and well-spoken. *"When I spoke, I didn't have any anger from him. If you got to know him, he was a nice person."*

Jack had had a relationship with a woman, DH, this ended in 2018-19. Jack was accused of domestic abuse offences against her and there are a number of allegations of him threatening DH after they had separated. They had at least one child together and DH is reported to have been pregnant with a second child by Jack in the period under review. Mental Health Trust records suggest that Jack also had an earlier child who would have been 11 or 12 at the time of Jack's death. Jack was prevented from seeing his children by DH and pursued visitation rights through the family courts. This appears to have been a significant source of stress to him.

Jack is described as suffering from anxiety and depression and is also noted as having a history of ADHD. He had been known to services, particularly Mental Health Services, for many years but his engagement was inconsistent and largely driven by crises.

Additionally, he had co-occurring mental health and substance use disorders. The picture of his substance misuse is incomplete, but he appears to have used a variety of substances including cannabis, alcohol and cocaine as well as the possible misuse of prescribed medication.

Given his cause of death, suicidality is a key concern for this review. In the two years before his death, the chronology contains 18 incidents related to suicidal thoughts or self-harming behaviour. Between 2007 and 2018, Jack had 24 attendances at a local

hospital, seven of these were for “overdose/MH/suicidal ideation”, (six were for chest pain, and eight were for other injuries). During the review period he had four local hospital attendances: these were for low mood and fleeting suicidal thoughts, as well as glass in a wound as a result of “falling into a glass door”. In December 2019 he was held under section 136 of the Mental Health Act following an overdose of his own medication in addition to being intoxicated. His brother also completed suicide during the review period.

In December 2019, Jack voluntarily attended A&E as a result of an assault (by an unknown person in Jack’s own home). He also attended hospital with many physical health concerns. For example, a cyst on his face, loose bowel motions, a head injury that caused him not to sleep and have nightmares and headaches. He had a problem with his jaw that caused him pain. The Hospital Trust commented that: “*these physical health concerns appeared to impact on (Jack’s) mental health. Many of the concerns were chronic and would have impacted his day-to-day quality of life.”*

Jack was in prison for four months prior to the review period (the dates are unknown). During the review period, he was involved with the Police on a number of occasions due to offences or incidents related to alcohol and drug abuse, his mental health, suicidal ideation, domestic abuse and concerns from professionals around the safety of children with Jack. In addition, on one occasion, he fabricated an assault allegation when Police Officers met him in the street. Police were also called to his address following a fight outside his property.

He always refused to engage with Alcohol and Drug Services, therefore, his main engagement was with Mental Health Services and with Primary Care for psychoactive medication. There are 42 dated entries in the Mental Health Trust IMR for the period under review and a few of these cover multiple dates. The number of entries increases noticeably during the last few months of his life. However, his interaction with services is poor and he often does not attend appointments or respond to phone calls.

He again engaged sporadically with his GP practice. Most of his contacts were driven by efforts to secure medications. He is known to have been prescribed Diazepam, Zopiclone, Amitriptyline, Co-codamol and Pre-gabalin. He also had a pattern of seeking further prescriptions due to, for example, leaving his medication in someone’s house.

His pattern of overdoses led to multiple Ambulance Service call outs. Often these calls appeared unnecessary or were apparently by someone else who was concerned about him. Jack was frequently non-compliant with the paramedics.

Jack also had issues around his housing and tenancy agreement. He was threatened with eviction towards the end of his life and a Mental Health Trust Key Worker was allocated to support him through securing more stable accommodation.

## 10. Chronology

A chronology of Jack'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.

## 11. Overview

Jack is an individual with his own unique characteristics; but he is also representative of a group of clients who pose a challenge for services. Individuals with both mental health and substance use disorders who have other physical and social problems, make repeated unplanned or crisis use of services, and fail to follow through on agreed or recommended actions. Jack's life offers a chance to reflect on how local practitioners could work more effectively with these clients.

The key challenge for services was that Jack did not engage with them in the expected manner. He terminated contact, disengaged from treatment and did not follow professional advice. It was very easy, therefore, for busy and over-stretched services to turn their attention to more compliant clients. In many cases, this prioritisation of clients who are willing to engage may be appropriate. However, that is only the case if it is based on a good understanding of the risks and vulnerabilities of those who are harder to engage.

Therefore, the first step to continued intervention with a difficult to engage individual is identifying the need for ongoing intervention. As a result, two key themes for this review are:

- Risk assessment and risk management (particularly with regard to suicidality); and
- Record keeping.

Another challenge with difficult to engage individuals is:

- The use of the mental capacity legislation.

An over-emphasis of the person's "right to make unwise decisions", at the expense of other aspects of the framework can hinder work with this client group.

If positive steps were to be taken with Jack, then professionals needed to recognise that constructive approaches exist for working with individuals who are difficult to engage. These will embrace other themes explored in this review:

- Substance misuse and the management of dually diagnosed clients
- Safeguarding
- Multi-agency working

It is not possible to say that anything could have been done that might have prevented Jack's suicide. However, agencies should always ensure that best practice is pursued with difficult to engage individuals.

The last months of Jack's life were under the COVID-19 lockdown restrictions. This undoubtedly impacted on the way services responded to his needs and the review has considered this in its analysis.

The following sections explore the themes set out above. The outcomes are then brought together again in the sections on Findings and Recommendations.

## 12. Assessment

### 12.1 Risk assessment and risk management process

The agency best placed to take a lead on identifying and managing Jack's risk was the Mental Health Trust. This is mainly because they had the most contact with him. The Trust's IMR is clear about the lack of a robust risk assessment process with Jack: "*The Trust's Clinical Risk Assessment and Management policy stipulates that consideration of risk must be documented at every contact by key workers to their service users to ensure that the risk of suicidality/deliberate self-harm and harm to others has been explored. It was noted within the SI (serious incident) investigation that there were omissions in documentation and acknowledgment of a lack of adherence to the Clinical Risk Assessment and Management policy.*"

As an example, in 2020, Jack was threatening suicide due to the risk of homelessness and had raised concerns with his MP. The Mental Health Trust allocated a Key Worker to Jack's case. Jack agreed to be referred to the Mental Health Social Care Team; however, there is no evidence on his electronic records (EPR) that Jack's risk was assessed during this period; despite documentation to state that he was feeling suicidal and was at risk of homelessness.

In addition, the Trust has reported that there:

- were missed opportunities to undertake comprehensive risk assessments to support Jack;
- were omissions in documentation and a lack of adherence to the risk assessment policy;
- was a lack of robust risk assessment following contact with Mental Health Liaison services;
- were missed opportunities to update the risk assessment on several occasions;
- was a lack of risk assessment when considering his risk of homelessness and previous suicidal thoughts;
- was a lack of process to support robust telephone risk assessment;
- were failures to update the risk assessment at least every 6 months: the last RiO risk assessment was completed more than 6 months prior to Jack's death;
- was a lack of consideration of the associated increased risk that Jack's brother's suicide may have had on Jack's wellbeing in November 2020.

At a more specific level, the circumstances of Jack's death highlight an important practice point. Jack's Key Worker spoke to him less than 24 hours before his death. He described him as sounding "okay". This underlines how important it is to look beyond simple client report and to have a comprehensive understanding of a person's

risk. This is even more crucial when the person's behaviour is characterised by impulsivity as seems to be the case with Jack.

Jack was not considered to be at high risk at any point in his later contacts with the Trust's Mental Health Services, therefore staff involved in his care reported that the Trust high level risk register would not have been appropriate. However, the problem is that the lack of a robust risk assessment did not allow staff to analyse whether the high-level risk register could have been a beneficial tool.

The Trust has recognised these issues and identified steps to be taken to address them. It should also be noted that COVID restrictions meant that Jack was not seen face to face by any Trust staff member after June 2020.

The Mental Health Trust was not the only agency to have contact with Jack. The Police undertook BRAG risk ratings on Merlins[1]. The Police IMR suggests that the ratings were appropriate but raises questions about the need for subsequent multi-agency strategy meetings. The Trust SI investigation considered the Merlin reports in the context of Jack's risk. In August 2020 a Merlin report was received by the Mental Health Trust detailing that Jack had approached the Police after superficially self-harming. The SI report considers that more action should have been taken as a result and recommends that the appropriate clinical steps are taken following each report. The Trust have implemented a process for an individual clinician to review and manage the Merlin reports and undertake appropriate risk planning.

### 12.2 Should Jack have been regarded as high risk?

The Trust's SI report has acknowledged gaps in the process around Jack. However, the central question is whether Jack should have been regarded as high risk and whether, therefore, different actions should have been taken to address that risk.

In statistical terms Jack's suicide was not a surprise. He had many risk factors associated with completed suicide. He had a long history of apparent suicide attempts and self-harm incidents. In the review period, there are at least 18 separate incidents involving suicide threats or actual harm to self. The chronology highlights at least another 6 or 7 such incidents between 2007 – 2018. Demographically, he is a White British male living alone without an intimate relationship or job in an area with a high deprivation score. He has lost contact with his children. He was at risk of homelessness. He misused alcohol and drugs and had a diagnosis of depression. Above all, in the period leading up to his suicide, his brother completed suicide. All of these are known to be risk indicators and cumulatively increase risk.

It should also be noted that Jack had indicators of risk to other people. This is most clearly seen in the violence towards two women with whom he had relationships. However, there are other incidents and in 2018 Ambulance Service staff entered his home and found that *"there were weapons, knives, axes and bats littered in the property".*

[1] Police reports concerning vulnerable people

Three other features of his presentation come together to reinforce the picture of a raised level of risk:

- His pattern of poor engagement with services
- His impulsivity
- His substance use / co-occurring disorder

Improved risk assessment will require more training around all of these factors. Jack's keyworker acknowledges that although he had received "a lot of training", more risk training would have been useful. The Mental Health Trust also acknowledges that awareness around the key demographics from 'The National Confidential Inquiry into Suicide and Safety in Mental Health' might have highlighted factors that placed Jack in the high risk suicide and safety category.

However it is important to note that training on both suicide and risk as well as many other themes was interrupted by the Covid lockdown.

### 12.3 Adequacy of notes and care plans

The Trust's SI found that more generally: record keeping did not meet the required Trust Standards e.g.:

- clinical discussion in the zoning meeting was not documented within Jack's EPR;
- the Key Worker's attempted phone contacts were not documented;
- contact with Jack's mother was not documented;
- there is a lack of evidence that the Consultant's plan was embedded within the care plan provided by his Key Worker and considered at his weekly review.

The Trust SI report found that there were no care plans completed within the RiO care plan template. (Although it is not essential for care plans to be completed within the template, the template supports staff to provide a focused review of appropriate plans of care within the scope of the Mental Health Services.) The template also prompts discussion and agreement with service users.

### 12.4 Non-engagement

The adequacy of risk assessment is a key issue in this review. However, the more practical challenge with Jack was that he was very difficult to engage constructively in interventions. Jack had frequent contacts with services but these were almost always in crises. This made it very difficult to undertake the support that would have been required to reduce his risk and stabilise his situation.

The original referral for consideration as a SAR highlighted *"concerns over services issuing discharge closure letters to people when they disengage. This is a potential red flag that someone is in crisis. Part of the issue with mental health is the struggle to engage with help and support offered."*

It has to be acknowledged that the last nine months of Jack's life were during the Covid lockdown which made engagement much more challenging. However, over the two

years of this review there were 26 identified incidents in which Jack had failed to attend appointments, discharged himself from ongoing interventions, turned services away or been hard to contact. This pattern was in place prior to the review period. The points at which he is in contact with services tend to be points of crisis. This is not simply about the Mental Health Trust. This pattern characterised his interaction with other services including the Hospital, Primary Care, the Ambulance Service and the Local Authority. For example, just 16 days before his suicide, the local authority closed his case after a series of unsuccessful telephone calls. The Primary Care IMR also highlights the challenge of engaging Jack.

This pattern raises questions about adherence to non-engagement policies and the adequacy of those policies.

As with the related issue of risk assessment, the Mental Health Trust has recognised problems in the application of the missed appointments policy. The SI report states that *As per the missed appointments policy it is expected that as soon as reasonably practical; 'following a missed appointment the practitioner will review the current risk assessment and existing care plan'. There is no evidence from the… EPR that Jack's risk was discussed or considered at this contact, despite evidence to show that the missed appointment was noted.* The Trust has recognised this issue and has indicated steps to address it.

However, the more fundamental question is whether professionals view non-engagement in the right way. Non-engagement can easily be seen as a *client failure* and an indicator of a lack of need for services. Should it not rather, as the original SAR referral suggested, be seen as an indicator of someone who is struggling and needs more assertive intervention?

A single failure to engage may not require a more assertive response, but a repeated pattern of such failures must raise questions about vulnerability, impulsivity and the level of need. The problem is that with Jack this pattern is spread across a number of agencies and each one has only a partial picture of this pattern. This also raises questions about the need for, and the adequacy of, multi-agency working which will be considered in section 13.1.

### 12.5 Impulsivity

Impulsivity is behaviour characterised by little or no forethought, reflection, or consideration of the consequences. Impulsive actions are typically "poorly conceived, prematurely expressed, unduly risky, or inappropriate to the situation and often result in undesirable consequences. Impulse control disorder is recognised as a condition in DSM-5.

The chronology of Jack's life suggests that his behaviour is characterised by impulsivity. The many incidents of self-harm, his emergency service calls, his sudden disengagements from treatment and his violence towards his ex-partner all highlight this pattern. The suicide that ended his life appears to have been a "spur of the moment" decision.

It is easy to see this simply as "the way Jack was". Impulsivity can be seen as a negative character trait rather than as signs of an underlying disorder. However, higher levels of impulsivity can be associated with head injuries, foetal alcohol damage, physical abuse, early onset substance use and, in particular, Attention Deficit Hyperactivity Disorder (ADHD). Jack may well have had, at least, the latter two of these risk factors. For example, in 2009 when he was seen by the Mental Health Trust Jack's stepfather raised suspicions that he suffered from ADHD; however, this had never been diagnosed." A discharge summary in December 2019 states – *"Impression mental and behavioural disorders secondary to illicit substance misuse and possible features of ADHD… Jack would benefit from ASD/ADHD assessment."* He had also been in prison at some point in his adult life and it is known that 60% of adult male prisoners have histories of brain injury.

This review is not the place for a detailed exploration of how to assess and work with impulsivity. It is worth noting that there are tools for assessing impulsivity and psychologists have also developed approaches to working with this presentation. However, the key point is that professionals need to be aware of, and looking out for, patterns of impulsivity in clients and see these as a marker of the need for professional curiosity and potentially action.

Recognition of the impact of impulsivity or impulse control disorder does not seem to have informed the work undertaken with Jack. In particular, his impulsive behaviour did not suggest to staff that systems of referrals and appointments which would work for the average member of the public are unlikely to work for someone in his situation. Impulsivity should have been explored and considered as a particular risk factor in his presentation and his suicidality.

### 12.6 Substance use and co-occurring disorders

In the IMRs, constant reference is made to Jack's substance use.

- In 1999 (age 11) he was described as having "Cannabis…and Cocaine type drug dependence."
- In 2016 his GP noted Diazepam dependence.
- In 2017 his GP noted drug dependence and alcohol withdrawal syndrome.
- In 2018 Jack called the Police regarding his drink problem and the Ambulance Service document evidence of heavy drinking.
- In 2019 A Mental Health Trust summary describes *mental and behavioural disorders secondary to illicit substance misuse and possible features of ADHD*. Trust notes describe dependency on Diazepam and drug and alcohol misuse.
- In February 2019 Hospital notes state *"Alcohol binge occasionally and recently".*
- In December 2019 Mental Health Trust notes that Jack continues to use large quantities of diazepam and cannabis. He presented to Mental Health Services with a "*strong smell of alcohol* (and) *unsteady on both feet".*
- In January 2020 Jack's GP *"warned of the dangers of taking such a concoction of meds – Side effects discussed again and needs to try to gradually come off Diazepam. Longstanding issues with chronic pain, anxiety, drug addiction/overdosing."*

Throughout the review period, there are contacts with prescribers seeking psychoactive medication or describing claims that he needs replacements for lost psychoactive medication.

However, at other times the messages about his substance use are more equivocal

- March 2019 – *"no illicit drugs has cut down on alcohol"*.
- October 2019 – *"no alcohol, smokes £20 of cannabis a week"*.
- November 2020 – *"Jack advised he has reduced his alcohol intake over the last 2 weeks. Jack continues to use Cannabis (up to 2 times per day but is trying to cut down)."*

As a result of his substance use and mental health concerns Jack can be regarded as having co-occurring disorders or a "dual diagnosis" (see 13.4). In October 2019 the Mental Health Trust notes state that *"it was agreed that Jack had complex mental health difficulties and problematic drug/alcohol use that exceeds what primary care can support."* The Trust's SI investigation quotes a staff member as identifying that as *"Jack had a dual diagnosis; he should have been considered a complex case and therefore should not have been key worked by a junior member of staff."*

It is important that substance misuse is accurately assessed and patterns of use and their impact identified. This does not seem to have happened in a structured way with Jack and there is no agreed formulation or understanding of the nature of his substance misuse.

## 13. Intervention

The previous section has argued that Jack should have been regarded as a high risk / complex client who required a more intensive and assertive response than he received. This section explores possible interventions that could have made a difference.

### 13.1 Multi-agency management

Jack is representative of a group of clients who may have a moderate impact on each individual agency; but, when looked at across a number agencies, his impact can be seen as far more significant. These individuals can easily slip through the net because they do not trigger the highest level of concern in any one agency. For these individuals a multi-agency perspective is essential.

Multi-agency management was almost completely absent from this case. The referral for consideration as a SAR comments that: *there may be a NEL system issue around how we co-ordinate these complex multi-agency cases.* It asks: *Could there be a case for having an adult MASH?*

Other IMRs also comment on the absence of multi-agency management:

- The Police IMR comments on the lack of a strategy meeting with Adult Social Care and comments that: *this may need considering as part of any review*.
- The Mental Health Trust IMR comments that the lack of communication between services was highlighted as a service care and delivery issue. It also comments on the lack of communication between MHSC and the Trust. The SI investigation identified the need to review communication pathways with MHSC to further support service users receiving joint care.

Jack would have benefited from being the subject of a multi-agency forum. He had a significant and repeated impact on a number of services and was regarded as an individual with complex needs by the Mental Health Trust.

This report could analyse this issue from a number of angles; however, the simplest approach is to state that Jack's needs are likely to have been better met through multi-agency discussion and management and that did not happen. This raises questions about whether there are appropriate local multi-agency forums for the discussion of someone with Jack's presentation. It has been highlighted that Barking and Dagenham has a multi agency Safeguarding Adults Complex Cases Group. This sits under the governance of the SAB. This review cannot analyse the adequacy of these local groups that have not been part of the IMR process. It is for local partner to consider whether there is an appropriate forum and whether it is being used sufficiently by local professionals.

### 13.2 Procedures for managing non/engaging clients and assertive outreach

Difficulty of engagement is a key feature of Jack's presentation and is seen in many other SARs. This highlights the need to have a local policy or procedure which guides professionals on how to respond to non-engagement. This will help them move beyond simply seeing non-engagement as a client failing and recognise it as a potential indicator for intervention.

Jack'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 concerns and where they should be escalated to;
- how to practically intervene with hard to engage clients.

A range of evidence identifies "what works" with difficult to engage clients. This is most clearly summarised in Alcohol Change UK's *Blue Light project manual.*[2] Further back, the Sainsbury Centre for Mental Health published *Keys to Engagement*[3] which identified similar approaches. More recently, both forthcoming clinical guidelines on alcohol use disorders and the Carol SAR from Teeswide also endorse the same approach.

At the core of this approach is a multi-agency management group to guide and support work with the individual, as advocated in 13.1 above, plus

- A care package centred on intensive assertive outreach which will require the willingness to be consistent and persistent and to allocate time to the task of engaging an individual.

Jack would have benefited from the availability of specialist assertive outreach staff, possibly based in the substance misuse service, who can work with this client group. This resource does not seem to be available locally but is used elsewhere e.g. Sandwell, Salford, Northumberland. This approach is not exclusive to people with substance use disorders and would benefit other hard to engage individuals.

### 13.3 Substance use disorders

No single consistent picture emerges about the nature or degree of Jack's substance use. This may reflect the changeable nature of his drug and alcohol use, but it does also suggest that key services e.g. Mental Health Services, Health Services, Adult Social Care and Primary Care were not using standardised alcohol and drug screening tools.

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 using the AUDIT alcohol screening tool and using professional curiosity to

[2] For transparency purposes it should be noted that the author of this report is the co-author of the Blue Light project manual.

[3] keys_to_engagement.pdf (centreformentalhealth.org.uk)

explore this issue. The same principle is applied to drug misuse in NICE guideline [NG64] *Drug misuse prevention: targeted interventions*.

Best practice would ensure that consistent drug and alcohol screening tools are routinely being used by all relevant professionals, whether in Primary Care, Mental Health Services or any other appropriate adult service. This is an area of work on which local authority Public Health Teams should generally take the lead. The results of these screenings should be recorded in notes and shared with other agencies when required.

In Jack's case, it is positive that education was given in both Mental Health Services and Primary Care about the harmful effects of the misuse of prescription medication, particularly in combination with illicit drugs and alcohol. It is also positive that a patient responsibility agreement for controlled substance medications was established with him in Primary Care.

On a number of occasions there are appropriate suggestions that Jack should go to the local drug and alcohol services (e.g. 2016, March 2019, February 2020, November 2020.) However, Jack refused to work with the service and there is no evidence that he ever engaged with them.

In working with substance use disorders, making a referral is the correct first step. Indeed, on the first occasion it may be justifiable to simply give information about the service and signpost the individual. However, when it is clear that Jack is not going to engage, an alternative referral strategy will be required. He is likely to need a more active bridge-building process to encourage him to engage with the Substance Misuse Services on the part of Mental Health Services or a more outreach focused approach from the Substance Misuse Services. This may suggest the need to develop the visibility of Substance Misuse Services and their capacity to reach out into the community and engage clients who are not ready to change.

With Jack, a degree of resignation to failure appears to have characterised these referrals. It is not even clear that he was discussed at the regular monthly meeting between the two services. The SI report states that: *"The operational lead advised that he was not discussed at the meetings leading up to his death as there had been historical numerous referrals to CGL and Jack had either declined or not engaged. Therefore, both services were aware that Jack would not engage, and discussion was not deemed necessary."*

Furthermore, it was suggested that Jack had the mental capacity to make this decision and, therefore, his choice not to engage should be accepted as the final word. This review argues that this is a misunderstanding of the mental capacity framework and this theme is explored further below (section 13.6).

Some of the care planning around his substance use disorder appears unrealistic. The latest care plan for Jack from the Mental Health Trust was developed in August 2020. This specified that he would "*increase day activities and…refrain from illicit drugs*". The Trust SI investigation generally found that "the care plans lacked focus..." This seems to be the case with this plan which seems to be unrealistic about the

degree of challenge in “refraining from drugs” and the degree of support that might be required.

The Ambulance Service raises issues around the impact of *unconscious bias in relation to substance and alcohol misuse*. This case suggests that this may not be an issue that is exclusive to the Ambulance Service. But it is positive that the Ambulance Service is taking steps to challenge such bias in its mandatory training.

### 13.4 Co-occurring disorders

Jack’s care also raises questions about the more specific issue of the management of people with co-occurring substance misuse and mental disorders.

Any work with this client group needs to be undertaken within the guidance provided by:

- PHE / NHSE – Better care for people with co-occurring mental health and alcohol and drug use conditions - 2017
- NICE – National Guidance 58 – Co-existing severe mental illness and substance misuse - 2016
- Psychosis with coexisting substance misuse – NICE Clinical Guideline 120 – 2011

The 2017 guidance asserts two key principles

- 1 *Everyone’s job.* Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.
- 2 *No wrong door*. Providers in alcohol and drug, mental health and other services have an open door policy for individuals with co-occurring conditions, and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.

These principles did not seem to characterise Jack’s care. As has been said, Mental Health Services appear to have simply offered Alcohol and Drug Services or signposted him in their direction. There does not appear to have been an effort to build a joint care plan and one whose starting point would be the recognition of the need to engage Jack into care.

### 13.5 Safeguarding and Adult Social Care

Jack had relatively little contact with Adult Safeguarding or Adult Social Care. Jack was the subject of a safeguarding alert in October 2018. The case was passed to the Mental Health Social Care Team. Attempts were made to contact Jack both by phone and home visits. None were successful and the case was closed due to non-engagement.

In December 2019, there is another contact with the Intake Team due to concerns raised by a Revenue Recovery Officer. In November 2020, Jack was allocated for

social care assessment. Three calls were made to Jack to arrange an appointment for assessment. No reply was received to any of these calls; therefore, a letter was sent to Jack advising of closure due to non-engagement. As a result, during the period under review there was no safeguarding adults plan / risk assessment or care plan.

This again raises questions about the response to difficult to engage clients. However, the main question is whether further safeguarding concerns should have been raised about Jack. Three agencies acknowledged missed opportunities:

- Jack had a number of hospital attendances. The last attendance …was in…December 2019, a year before his death. He predominantly presented with mental health issues, self-harm or other injuries. There were potentially some missed opportunities for making safeguarding referrals.
- Ambulance Service staff were aware of Jack's history of poor mental health and substance and alcohol use disorders. However, on most occasions, the Paramedics do not seem to have explored the support Jack was receiving or what support he may have needed, there was a lack of discussion and escalation around safeguarding concerns… Two of the Ambulance calls were significant missed opportunities for staff to safeguard Jack (09/12/2019 & 16/03/2020).
- A safeguarding alert was not considered by the Mental Health Trust duty nurse, following Jack's contact on the 15/12/2020; whereby he raised concerns that he had been burgled… The safeguarding process should have been discussed with Jack to establish his views, wishes, and expected outcomes…·Safeguarding concerns should have been explored and considered and discussed with Jack when there was a threat of homelessness.

Only the Police and Primary Care did not identify missed opportunities for raising safeguarding concerns. The Ambulance Service has taken specific steps to address what are perceived as practice shortfalls including increasing safeguarding training.

The IMRs do not make it clear why more safeguarding referrals were not made. It is possible that a young man with impulsive behaviour and a pattern of substance misuse is (wrongly) not regarded as a candidate for safeguarding. Yet when he attended hospital in both February and December 2019 he reported as not having eaten for several days and on the latter occasion as having been the victim of a reported assault by an unknown person in his own home. The General Hospital Trust IMR recognises that this pattern combined with alcohol suggests a risk of self-neglect.

In December 2020, the Mental Health Trust Key Worker did not submit a safeguarding alert because it was felt that as the client had already involved the Police there was no reason for a safeguarding alert to be considered.

The SI investigation reviewed whether there were any safeguarding considerations in relation to Jack prior to his death. It states that: *"Whilst under Trust services, professionals advised that at no point was there reason to doubt Jack's mental capacity, or to question his decision to make unwise choices to his care, treatment, and/or lifestyle. Therefore, the Trust had not been alerted to any immediate*

*safeguarding concerns that had warranted attention whilst Jack was under the care of the Trust.*"

This latter response does suggest that staff were not recognising that someone with mental capacity could still require safeguarding. More generally, the lack of safeguarding concerns indicates a professional development need.

NB – Jack raises a separate safeguarding issue. Section 9 of this report highlighted the uncertainty about the number of children that Jack had fathered. It was highlighted that this gap in knowledge could be an issue in terms of whether there were any child safeguarding issues associated with Jack and his role as a parent. It highlights the importance of understanding the number of children that someone may have, even if they are not living with them, so that accurate risk assessments can be undertaken.

### 13.6 Mental capacity

There are five specific occasions during the review period on which Jack's mental capacity is referred to in the IMRs. All of these are in crisis situations and involve the Ambulance Service:

- 09/12/2019 Ambulance Service "deemed" Jack to have the capacity to make the decision not to accept treatment.
- 09/12/2019 (2nd incident) Ambulance Service "deemed" Jack to lack capacity to care for himself after an overdose
- 16/03/2020 Ambulance Service "deemed" Jack to have the capacity to make decisions about treatment following an overdose.
- 19/10/2020 Ambulance Service and Police "agreed" that Jack had the capacity to make decisions following threats of suicide.
- 12/11/2020 Ambulance Service state that Jack had capacity to decline to be conveyed to hospital.

In relation to Jack's decision not to engage with CGL, the Mental Health Trust IMR comments that: *"At no point was there reason to doubt Jack's mental capacity, or to question his decision to make unwise choices during each contact."* In discussion with one Trust staff member questions were asked about how the MCA framework was applied? The answer was simple *"That was not considered – he had capacity."*

However, more importantly, the Mental Health Trust IMR also says that: *"There was no evidence in Jack's … records to support that all practical steps had been explored in relation to capacity including provision of relevant information to support informed decision-making."*

Assessing the mental capacity of people with substance use disorders can pose real challenges. It is easy to assume that their choices are simply "unwise decisions" rather than the result of a lack of capacity. It is easy to categorise their decisions as *lifestyle choices* rather than understanding the more complex reasons behind their behaviour.

In particular, careful consideration needs to be given to whether people with substance use disorders lack "executive capacity". Can they put into effect (execute) the things

that they say they are going to do? Repeated failures to execute decisions should raise questions about their mental capacity.

This review has received very little evidence from people who worked directly with Jack. It is, therefore, very hard to make any judgements about how the Mental Capacity framework was used with him. All that can be said is that it is important that the legislation is used in the same way with people with substance use disorders as with any other client group.

The report of '*The 2013 Mental Capacity Act 2005: Post-Legislative Scrutiny'*, specifically highlighted the challenges posed by clients like Jack: *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. …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.*

Even if Jack did have capacity, he still needed professionals 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; it is important to take all possible steps to try to help them reach a decision; it is important to provide appropriate advice and information; providing relevant information is essential in all decision-making.*

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…*

Jack may or may not have had capacity in terms of the Act. Nonetheless, even if he had capacity, he would need far more help, for example, to access Substance Misuse Services than a simple offer of services or signposting.

## 14. Housing

Jack had problems with his accommodation and towards the end of his life was threatened with eviction. He raised this concern with his MP. Help was offered: he was referred to the Mental Health Social Care team and his Key Worker in the Mental Health Trust's main role was initially to help him with his housing application. This process was still ongoing at the time of his death. It is unclear what impact, if any, this had on his suicide or whether this was an area of work that needed more attention.

## 15. Covid-19

Covid-19 does seem to have impacted on Jack's care. It is hard to know whether he would have received a more assertive response from Mental Health or Substance Misuse Services at other times, but it is fair to acknowledge the impact on his Mental Health Key Worker's ability to engage with him because staff were unable to make home visits. A more specific impact was that all Mental Health Trust training was cancelled from March 2020. This meant that Jack's Key Worker's suicide prevention training was cancelled in March 2020.

## 16. Findings

The Mental Health Trust IMR states that: *"This case highlights the important factors that can contribute towards good practice, service delivery and partnership working; i.e. conducting individualised holistic assessments of a person's needs, robust risk assessments, person-centred care plans which capture the person's voice, views, wishes, beliefs, feelings and expected outcome, specialist training for all staff in relation to suicide assessment/prevention, referral/escalation, signposting and effective communication between agencies, especially in regards to complex case management and potential safeguarding concerns."*

This report agrees wholeheartedly with that analysis. However, a second key issue with Jack was that he was difficult to engage in services: failing to attend appointments, not engaging with planned interventions and failing to follow professional advice. As a result, he often slipped through the gaps between services.

Therefore, Jack's death particularly highlights the importance of good risk assessment which draws on worker's assessment skills but is founded on the clinical evidence about the factors that predict the risk of suicide. Such assessments will then highlight the need to take further and more assertive action with hard to engage clients. It also highlights the importance of good training on risk assessment.

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 these difficult to engage clients and includes such issues as the level of risk that requires a more assertive approach and identifies the need to escalate the more vulnerable, hard to engage clients, to a local multi-agency forum for joint management. This would be further improved by having services that are able to reach out and engage clients who are reluctant to engage with mainstream services.

Jack was also representative of a group of clients who may have a moderate impact on each individual agency; but, when looked at across a number agencies, their impact can be seen as far more significant. These individuals can easily slip through the net because they do not trigger the highest level of concern in any one agency. For these individuals a multi-agency perspective is essential.

The absence of multi-agency management was a particular feature of the Jack case. Irrespective of the development of an engagement policy, it is important that there is an identified pathway into multi-agency management for complex clients. This will

need to link into the process for the local multi agency Safeguarding Adults Complex Cases Group which sits under the governance of the SAB.

Jack was a man with both a substance use disorder and mental health problems. The response to his substance use was characterised by a lack of detail about the history and nature of his use. This highlights the importance of standardised screening tools. More importantly there was a lack of involvement of Alcohol and Drug Services. Jack simply refused to engage with these services. This raises questions about the visibility and the outreach capability of local Substance Misuse Services.

Therefore, in addition to multi-agency management, it will be important to consider whether there is a need for investment in assertive outreach services that can work to engage treatment resistant substance misusers and other individuals with complex presentations into services.

Jack had co-occurring disorders. It is important to ensure that work with such individuals adheres to the standards set out in NICE and PHE/NHSE guidance documents. It is not clear that this was the case with Jack.

His presentation is also characterised by impulsivity. However, this was not identified as a particular feature that needed to be taken in to account in developing a care plan. Nonetheless there are good reasons, such as ADHD, to think that impulsivity was a factor in his presentation and it will be important to consider whether local agencies need to do more to identify and address impulsivity as a particular feature of individual care. In particular this will require professional curiosity on the part of workers to explore and understand the reasons for this impulsivity.

In the period under review, there were no safeguarding concerns raised about Jack. However, a number of agencies identified missed opportunities to raise such concerns. It would seem necessary, therefore, to remind agencies that safeguarding concerns can be raised about individuals with presentations like Jack. In one case it was suggested that because Jack had mental capacity, he did not require safeguarding. This appears to ignore that an individual with capacity can still require safeguarding.

The use of the Mental Capacity Act was also limited in his case. The only capacity assessments were carried out by the Ambulance Service. However, perceptions or assumptions about capacity acted as a barrier to further action being taken when he declined Alcohol and Drug Services. It is important that practitioners receive training on the use of the Mental Capacity Act with this client group and in particular consider the issues of executive function and executive capacity. Moreover, it is important to ensure that professionals do not see “having mental capacity” as being the end of efforts to help the person access the care that would benefit them.

## 17. Good practice

The IMRs identify three pieces of good practice:

- In December 2019 Jack contacted the Mental Health Trust in the morning to advise that he had a dentist appointment and could not make his scheduled assessment. The nurse arranged for him to be seen later that day.
- There is evidence that Jack's mother was contacted by services when concerns were raised regarding his non-engagement.
- When Police officers were submitting ACN MERLIN reports for Jack, they also put on reports for the children including Jack's unborn child. This enabled adult and child safeguarding partnerships to look holistically at the risk Jack's deteriorating mental health posed to himself and his children.

The author would add that:

- The education given in both Mental Health Services and Primary Care about the harmful effects of the misuse of prescription medication, particularly in combination with illicit drugs and alcohol and the patient responsibility agreement for controlled substance medication established with him in Primary Care are models of good practice.
- The Ambulance Service's recognition of the impact of unconscious bias in relation to substance use disorders and the steps taken to challenge such bias in its mandatory training are again models of good practice.

## 18. Recommendations

Recommendation 1 – The Barking and Dagenham SAB should reassure itself that there is robust local training on risk assessment which includes evidence about key predictors of a risk of suicide.

Recommendation 2 – The Barking and Dagenham SAB should lead the development of local procedures that guide professionals on how to respond to clients who are hard to engage in services. (These protocols could equally apply to vulnerable clients within and outside of the safeguarding context).

Recommendation 3 – The Barking and Dagenham SAB should ensure that those procedures support the escalation of the more vulnerable, hard to engage clients, to the Safeguarding Adults Complex Cases Group for joint management.

Recommendation 4 - Barking and Dagenham's Commissioning Team Team should consider development of assertive outreach capacity in Alcohol and Drug Services to support the engagement of hard to engage substance misusers.

Recommendation 5 – Barking and Dagenham SAB should advise agencies of the need to consider raising safeguarding concerns about people with substance misuse and/or co-occurring disorders.

Recommendation 6 – Barking and Dagenham SAB should ensure that guidance or training is available to support professionals to consider the use of the Mental Capacity Act in the context of difficult to engage clients including people with substance use disorders. This should include reminders about the importance of considering executive capacity.

Recommendation 7 – Barking and Dagenham SAB should ensure that there is training on working with, and pathways for, individuals who have both substance use disorders and mental disorders which adhere to the standards set out in national guidance.

Recommendation 8 – Barking and Dagenham SAB should support training to enable professionals to understand the impact of impulsivity in complex clients.

Recommendation 9 - Barking and Dagenham's Commissioning 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 Jack SAR

Were practitioners sensitive to the needs of the adult at risk in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about an adult at risk?

Did your agency have in place policies and procedures for safeguarding adults and acting on concerns about their welfare?

What were the relevant points or opportunities for risk assessment and decision making in this case in relation to the adult(s) at risk/or alleged perpetrator(s)? Do the assessments and decisions appear to have been reached in an informed and professional way?

Did action accord with assessments and decisions made? Were appropriate services offered or provided, or relevant enquiries made, in the light of assessments?

Where relevant, were appropriate Safeguarding Adults Plan/risk assessments or care plans in place? Had review processes been complied with?

When, and in what way, were the adult(s)'s wishes and feelings ascertained and considered? Was this information recorded?

Was practice sensitive to any protected characteristics of the adult(s) at risk?

Were senior managers, or other agencies and professionals, involved at points where they should have been?

Was work in the case consistent with agency and SAB policy and procedures for protecting adults at risk and wider professional standards?

Please comment on any aspects of the case or the agency involvement that are examples of good practice.

Are there any particular features of this case, or the issues surrounding the case, that you consider require further comment in respect of your agency's involvement?

Are there 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 considered as a result of this review report?