Adults and Health Committee – March 2024

ANTON and PAM - Safeguarding Adults and Domestic Homicide Review - Updates

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Cheshire East Council

Purpose and Process

- Purpose of a Safeguarding Adults Review and a Domestic Homicide Review
- Commissioned by the Safeguarding Adults Board (SAB) and Safer Cheshire East Partnerships (SCEP)respectively
- The participation and learning is owned by each Partner Agency
- Action Plans are overseen by the SAB/SCEP

ANTON and PAM

- **ANTON SAR**
- Anton was 64 when he died.
- White male of Slovakian origin
- He was found deceased in his property in November 2021
- He died of pneumonia but had other serious health problems
- His understanding of English was limited, and he relied on friends and professional interpreters to translate for him.
- His communication skills may have been further impeded by a stroke
- It is important to note that some of the review period coincides with the Covid restrictions
- He appears to have had a pattern of alcohol misuse
- There is limited indication of mental health problems, i.e. anxiety, but he did not engage with mental health services
- Socially isolated

- **PAM DHR**
- A referral was made to SCEP in 2019 following the death of Pam who was unlawfully killed by her boyfriend in August 2019. The Partnership agreed that the criteria for a Domestic Homicide Review were met.
- Pam was 53 when she died. She had experienced childhood trauma and as an adult suffered from anxiety, depression and suicidal thoughts. She was also Alcohol dependent.
- Pam had 5 children, one sadly died shortly after birth. Her adult children contributed to the DHR
- Pam was known to many different services and MARAC
- “It is easy to see someone who is a drinker and assume they are trouble, but my mum was not just a drinker, she was kind, loving, funny and a caring mum to us all”
- Her perpetrator was a Serial Domestic Abuse Perpetrator and had a diagnosis of Huntingdon’s Disease. He was sentenced to an Indefinite Hospital Order in April 2020
- Inquest set for May 2025

ANTON - Themes

- Loss of settled status and benefits
- Language and communication
- Service responses
- Difficult to engage with hard to reach/seldom heard people
- Mental capacity
- Escalation and multi-agency involvement
- Safeguarding concerns
- Alcohol misuse
- Covid

Anton: Recommendations and Actions

Recommendations

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

2. The 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.

3. The SAB should produce guidance for working with individuals who are seldom heard and often decline support

Actions

1. The SAB is working with DWP to produce a training package for Frontline Staff

2. The SAB has sought assurance from Partner Agencies that they have access to Translation services.

Unfriended adults have access to a paid advocate in Safeguarding Enquiries

3. Guidance has been produced to assist Practitioners when adults a risk miss appointments and Seldom Heard Guidance

Recommendations and Actions

Recommendations

4.The Cheshire East SAB should ensure that staff know how to escalate the more vulnerable, hard to engage/seldom heard clients, to a local multi-agency forum for joint management

5. 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”.

6. Cheshire and Merseyside ICB to ensure all contacts are recorded

7. Public Health to promote an Alcohol Screening Tool

8. SAB to ensure adherence to the Mental Capacity Act and consideration of Executive Functioning

9 The SAB to ensure practitioners raise a Safeguarding concern for cases of Self Neglect

Actions

4. The frequency of the Multi Agency Complex Safeguarding Forum has been increased from 6 weekly to 4 weekly meetings in 2024. Referral pathways have been improved

5. A series of One Minute Guides have been produced – including a Principals of Engagement Tool / Trauma Informed Practice Tool for Frontline staff /Seldom Heard Guide-

6. The SAR report was shared with all ICB/Place Designated/Named Leads to share the learning and was highlighted in our own place report .There has been discussions with Trust leads regarding the availability of information in multiple languages – which is being addressed

7. The SAB has worked collaboratively with Public Health to promote the use of a standard Alcohol Screening Tool

8. The SAB has completed a multi-agency survey to identify knowledge, skill and application – shared good practice and guidance on MCA. Bespoke videos to be produced

9. The SAB key focus for 2024 is on Self Neglect. Survey competed in Feb 2024. Tools

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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 who made assertive efforts in the last year of his life to engage with him and secure the help that he needed.
- Largely before the review period, his Housing Association, and in particular their 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, 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 Polish volunteer from a local service who could speak Russian and used a combination of both languages to communicate with him. Again outside the review period Mental Health Reablement identified a Polish reablement worker to support him because of linguistic similarities .

ANTON

7 Minute Briefing – ANTON

1 Background:

A referral was made to Cheshire East Safeguarding Adults Board following the death of Anton who died at home from pneumonia in November 2021. The SAR Panel met in January 2022 and the Safeguarding Board agreed that the criteria for a statutory Safeguarding Adults Review were met. The scope of the SAR covered the period 2019 – 2021, which coincided with COVID restrictions.

Anton was Slovakian. He was 64 when he died. 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. He had no family and appeared to be socially isolated. His understanding of the English language was poor.

Anton had poor physical and mental health and was known to many services.

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 fingernails, which appeared to show that he neglected his cleanliness / hygiene.

2 The Purpose of a Safeguarding Adults Review:

Establish the facts that led to the death and whether there are any lessons to be learned from the case about how local professionals and agencies worked together to safeguard Anton

- Highlight areas of good practice to be shared
- Identify how and within what timescales any actions will be acted on, and what is expected to change.
- Contribute to a better understanding of the nature of Adult Safeguarding
- Ensure that the experiences of Anton are heard regarding his experience of accessing care and support in Cheshire East.

3 Key Emerging themes:

Safeguarding practice: The SAR highlighted missed opportunities to raise a Safeguarding Concern. It also highlighted that the Housing Provider had contacted Social Care 17 times, but only 2 Safeguarding episodes were opened.

Mental capacity: Whilst a mental capacity assessment had been completed around Finances, opportunities were missed to explore executive functioning.

Inconsistent responses from services (e.g., failed service provision and short-term working) There were some areas of good practice, but equally some gaps and delays in service provision and home visits – leading to a deterioration in health

Working with difficult to engage clients: Due to Anton's language barriers, he would often miss appointments or disengage, and he lacked trust in services. This could lead to case closure

Multi-agency management: There were missed opportunities for Multi Agency Information Sharing

Problems with benefits payments: The loss of his settled status and welfare benefits had an impact on Anton's mental health and self-neglect

Working with people with limited English and poor communication skills: The SAR acknowledged good practice where Agencies had used Translation services, but also equally where Agencies sent letters/text messages in English.

The identification of possible alcohol use disorders: This was not sufficiently explored to ascertain whether Anton would have benefitted from Support

Good Practice: The SAR noted key professionals who tried to engage with Anton and improve his quality of life namely the Housing Association and Floating Support

4 Recommendations: The SAR made the following recommendations:

1. The Board Partners to ensure that vulnerable foreign nationals have access to expert support through the benefit system
2. All Agencies should make information available in native languages and use interpreters
3. The SAB is to provide guidance on how to Engage with Hard-to-Reach people
4. All Partners to utilise escalation procedures, Multi Agency Meetings, and the Complex Safeguarding Forum
5. The ICB to explore how it responds to chaotic and Hard to Reach Individuals
6. All Partners to ensure compliance with Mental Capacity Legislation, including Executive Functioning
7. All agencies to be aware of how to raise a safeguarding concern
8. Public Health to ensure Agencies use robust alcohol/drug screening tools

5 Practice implications:

When anyone is identified with complex needs and poor language skills, it is essential to provide information in an accessible way – both verbally and in written form.
When the person is seen to be Hard to Engage, it is important to understand previous life experiences and to provide consistent support.
Information sharing and accurate record keeping is essential.

6 Implementing change:

Discuss the themes with your team or service and consider how they may affect your practice. Determine what you or your team could do to act on these and implement any necessary changes.

7 Resources and further information:

Change Grow Live | Charity | We can help you change your life

Combined document to Support Adult Safeguarding Referrals_ (003) (002) (stopadultabuse.org.uk)

Learning from tragedies: an analysis of alcohol-related Safeguarding Adult Reviews published in 2017 | Alcohol Change UK

Resource Examples

Self-Neglect 7 Minute Briefing

SELF-NEGLECT AND ENGAGEMENT

This briefing is part of a series on self-neglect. Each briefing should be read alongside your Safeguarding Adults Board multi-agency policy, procedures, and practice guidance.

THE ISSUE

The Care Act 2014 incorporated self-neglect as an abuse category, recognising that self-neglect is a safeguarding concern for those adults in receipt of, or in need of care and support, when their health and well- being is being seriously compromised.

There are many reasons why an individual may self-neglect, including previous trauma, enduring and deteriorating physical and/or mental health conditions e.g. dementia, and addictions. Individuals who self-neglect often decline support and may not identify that they need support. There may be a limit to what professionals and family, friends and neighbours can do, if the adult is deemed to have mental capacity regarding how they live.

REASONS WHY ENGAGEMENT MAY TAKE MORE TIME

- The person may be embarrassed to have visitors and withdraw from family, friends, their community and professionals, becoming socially isolated.
- Anxiety, shame, and fear can be contributory factors to refusing to engage and sustaining engagement with others, including professionals.
- Refusal of support - this may be for many different reasons, but if there are concerns, it is important not to walk away.
- The person may have an excessive attachment to possessions, or be a rescuer of animals, due to issues with emotional attachment which can relate to previous trauma.
- The person may have lived in a particular way for many years, with deteriorating health exacerbating the risks to themselves and others.
- Anti-social behaviour.
- Mental health issues.

North East SAR Champions

Self-Neglect 7 Minute Briefing

SELF-NEGLECT: AN OVERVIEW

This briefing is part of a series on self-neglect. Each briefing should be read alongside your Safeguarding Adults Board multi-agency policy, procedures, and practice guidance.

SELF-NEGLECT: DEFINITION

Self-neglect covers a wide range of behaviour relating to care for one's personal hygiene, health or surroundings, and includes behaviour such as hoarding. Three recognised forms of self-neglect include:

- Lack of self-care – this may include neglecting personal hygiene, nutrition and hydration or health (e.g., non-attendance at medical appointments)
- Lack of care of one's environment – this may result in unpleasant or dirty home conditions, and increased risk of fire due to hoarding
- Refusal of services that could alleviate the above

WHAT TO LOOK FOR:

Adults who self-neglect are more likely to live alone, be an older person, experience mental ill-health, have alcohol or drug problems and have a history of poor personal hygiene or living conditions. Signs include:

- Not enough food, or food is rotten
- The home is filthy, odorous, hazardous or unsafe
- Major repairs/maintenance to the home is required
- Presence of human or animal faeces in the home
- Accumulation of possessions
- A large number of pets and/or abuse or neglect of pets
- The adult may:
  - Have dirty hair, nails and skin
  - Smell of urine and/or faeces
  - Have skin rashes or pressure ulcers
  - Have a poor diet and/or hydration
  - Show increased confusion or disorientation
  - Have deteriorating physical or mental health e.g. diabetes, dementia
  - Be socially isolated

MENTAL CAPACITY

One of the first considerations should be whether the person has mental capacity to understand the risks associated with the actions/lack of actions. Any action proposed must be with the person's consent, where they have mental capacity, unless there is a risk to others (such as a fire risk due to hoarding, or public health concerns). In extreme cases of self-neglect and/or hoarding behaviour, the very nature of the environment should lead professionals to question whether the person has capacity to consent to the proposed action or intervention and trigger a mental capacity assessment. Consider if the person has the functional capacity to make a particular decision and executive capacity which is the ability to carry out the decision. Please see links below for further information on executive capacity.

The Care Act Statutory Guidance recognises it can be difficult to distinguish between whether a person is making a capacitated choice to live in a particular way (which may be described as an unwise choice or decision) or whether:

- The person lacks mental capacity to make the decision; or
- There is concern regarding the adult's ability to protect themselves by controlling their own behaviour.

PAM – Themes and Actions

Themes

1. There were missed opportunities for multi-agency Information Sharing
2. Referral pathways and information from the Police to Social Care needed to improve (VPA's)
3. Risk assessments were not always completed or shared
4. Professionals' meetings and MARAC arrangements needed to improve

Actions

1. Adult Social Care Staff now have access to CWPs case records. IDVAs now sit within the Front Door Team
2. The Police have redesigned their services and introduced a Vulnerability Hub and VPA referral forms have improved to include better information
3. The RIC is now completed at 1st contact with DA services, the Adult Social Care Risk Assessment and Guidance has been updated
4. A new E-MARAC process has been introduced, dedicated Social Workers attend all MARACs, a Standing Operating procedure and One Minute Guide re MARAC is now in place. CEC MARAC has been approved and ratified by SAFELIVES

Themes and actions

Themes

5. More effective ways of working with people who harm/perpetrators

6. Lack of local emergency housing provision

7.Improve outcomes for Domestic Abuse Victims via the Crown Prosecution Services

8. Recognition of Adults at Risk who also victims of Domestic Abuse

9. Alcohol awareness/screening

Actions

5. Domestic Abuse Services now refer perpetrators to the Harm Reduction Unit. My CWA has specific services to work with those who harm Safer Film 1 Message to Perpetrators (vimeo.com)

6. Whole Housing Approach project launched in 2022. Cheshire East Housing received Domestic Abuse Housing Alliance (DAHA) accreditation in 2022

7. More work required with the CPS

8. Domestic Abuse and Safeguarding Training now available for Adult Social Workers. Dedicated workstream re Domestic Abuse, Dementia and Carers. All Partners have confirmed to SCEP that they have DA training in place.

9. Work with Public Health re GP access, Lifestyle of Prescription and Alcohol screening tools

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everyone's business

Self-Neglect 7 Minute Briefing

SELF-NEGLECT AND ALCOHOL AND SUBSTANCE MISUSE

This briefing is part of a series on self-neglect. Each briefing should be read alongside your Safeguarding Adults Board multi-agency policy, procedures, and practice guidance.

THE ISSUE

- Self-neglect can impact on an adult's wellbeing but the cause of this is not directly a result of physical or mental impairment or illness but arises from acts of their own, such as drug and alcohol misuse and risks associated with this.
- Attachment to their substance of choice and prioritising this above all else, can impact on their relationship with others.
- Definition of addiction is the loss of the ability to make choices. The Latin meaning for addiction implies enslavement.

LINKS TO ABUSE AND NEGLECT

- Increased risk of deterioration in physical and mental health.
- Risk of overdose or contaminated substances if drugs purchased on the street.
- Risk of engaging in criminal activity to fund drug or alcohol use.
- Increased risk of violence from others.
- Exploitation by others, including sexual exploitation.
- Increased risk of domestic abuse.
- Increased risk of suicide or misadventure.
- Financial difficulties can occur due to expenditure on drugs/alcohol resulting in debts and inability to pay for basic needs.
- Increased risk of homelessness if unable to adhere to tenancy agreements.
- Emotional or psychological harm due to increased social isolation.

A MULTI-AGENCY RESPONSE

Self-neglect cases involving drug and alcohol misuse require a multi-agency response, whether this is under safeguarding adults' procedures or as part of multi-disciplinary working more generally. There needs to be a clear understanding of the person's needs as a whole (not just in relation to their substance misuse). A team-around-the-person approach often works well, with a small core group of professionals established to closely monitor risks and the plans to manage risks.

7 Minute Briefing – PAM

1 Background:

A referral was made to SCEP in 2019 following the death of Pam who was unlawfully killed by her boyfriend in August 2019. The Partnership agreed that the criteria for a Domestic Homicide Review were met.

Pam was 53 when she died. She had experienced childhood trauma and as an adult suffered from anxiety, depression and suicidal thoughts. She was also Alcohol dependent.

Pam had 5 children, one sadly died shortly after birth. Her adult children contributed to the DHR

Pam was known to many different services and MARAC

"It is easy to see someone who is a drinker and assume they are trouble, but my mum was not just a drinker, she was kind, loving, funny and a caring mum to us all"

Her perpetrator was a Serial Domestic Abuse Perpetrator and had a diagnosis of Huntingdon's Disease. He was sentenced to an Indefinite Hospital Order in April 2020

2 The Purpose of a Domestic Homicide Review:

- Establish the facts that led to the death and whether there are any lessons to be learned from the case about how local professionals and agencies worked together to safeguard Pam
- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Prevent domestic abuse and carer related deaths and improve service responses where these issues are identified and responded to at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse
- Ensure that the experiences of Pam and her family are heard regarding their lived experiences and the impact of Domestic Abuse

3 Key Emerging themes:

Gender: Women are much more likely than men to be the victims of high risk or severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women. Pam's case was heard at MARAC on 5 occasions between 2018/19

Assessing Risk and Safeguarding: It was noted that a significant number of VPAs had been submitted but not all agencies received them. This led to missed opportunities for information sharing including previous incidents of abuse, liaison and assessments under the Care Act

Health Vulnerabilities and Complex Needs: At least 20% of high-risk victims of abuse report using drugs and/or alcohol. Pam was more vulnerable to abuse due to complex health needs. She had a good relationship with her GP and IDVA. There was a pattern of accessing services at crisis points but would disengage leading to case closure. Care Act eligibility includes "substance misuse and brain injury".

Previous criminality of the perpetrator: Pam's perpetrator did not engage with services including harm reduction schemes. The review highlighted limitations of the wider criminal justice systems in holding perpetrators to account.

Housing Provision: Offers of refuge were declined due to distance and accessibility. The perpetrator

7 Resources and further information:

Cheshire East Domestic Abuse Hub:
Tel: 0300 123 5101 or
cedah@cheshireast.gov.uk
Huntingdon's Disease Association:
Helpline 0151 331 5444
Change, Grow, Live:
Eastcheshire.info@cgl.org.uk
St. Mary's Sexual Assault Referral Centre: 0161 276 6515
Rape and Sexual Abuse Support Centre: 0330 363 0063

6 Implementing change:

Discuss the themes with your team or service and consider how they may affect your practice. Determine what you or your team could do to act on these and implement any necessary changes.

4 Recommendations:

It should be noted that some actions have been put into place since the incident and the DHR publication.
The DHR made the following recommendations:

- Vulnerable Person's Assessments (VPA's) should be clear and a robust pathway to be established
- Multi Agency Professionals Meetings/Full MARAC meetings to be held for High Risk/Complex cases
- Promote Behaviour Change Programmes for Perpetrators
- Mental Capacity Assessments to be completed to evidence decision making
- Risk Indicator Checklists to be completed including Honour Based Abuse and Stalking
- The DA Partnership to collate and measure successful prosecutions
- Multi Agency Training regarding Domestic Abuse, Adult Safeguarding/VPAs and to create opportunities to understand roles and responsibilities

5 Practice implications:

When anyone discloses Domestic Abuse, it is essential to listen and believe them and promote safety and wellbeing. When there is a concern for a person's safety, it may be necessary to override consent.
Information sharing and accurate record keeping is essential.

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Resources

1. Executive summary DHR for Pam (cheshireeast.gov.uk)

- Domestic Abuse Act 2021 - GOV.UK (www.gov.uk)
- Key findings from analysis of domestic homicide reviews: October 2019 to September 2020 (accessible) - GOV.UK (www.gov.uk)
- Violence against Women and Girls Strategy
- Safer Film 2 Keeping Women Safe (vimeo.com)
- Safer Film 5 Safety Bus (vimeo.com)
- Safer Film 3 Good Sam App (vimeo.com)
- Safer Film 4 Reporting Crimes (vimeo.com)
- Domestic Abuse Getting Help (cheshireeast.gov.uk)

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Thank You

- Cheshire East Adult Social Care:
- Tel 0300 123 5010 Office Hours/0300 123 5022 Out of Hours

- Cheshire East Domestic Abuse Hub:
- 0300 123 5101 or 999 in an emergency
- cedah@cheshireeast.gov.uk

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