Safeguarding Partnership Board

Learning Report

Serious Case Review (SCR)

‘Mr Arthur’

A Learning Report - Serious Case Review (SCR) 'Mr Arthur'

This report summarises the key learning points from the SCR on an adult, 'Mr Arthur', (not his real name) and has been written to support the dissemination of learning to practitioners and across services.

1.1 Introduction

This case concerns the case of Mr Arthur, who was found dead by police officers at his home in January 2014. They had gone to his home following a concern being expressed by a neighbour that he had not seen him for some time. The finding of an inquest held in June 2014 was that Mr Arthur, "had died some six to seven months previously, cause of death unascertainable".

1.2 Overarching Themes of SCR

- **Missed opportunities to engage**

With that great clarity of vision that hindsight gives us, it is tempting to suggest that what happened to Mr Arthur was at least contributed to by errors of professional practice. There were some opportunities that seem to have been missed to engage him in the management of the negative consequences of his regularly recorded decision/choice to continue to drink. However, the General Hospital records in particular, report him as discharging himself prematurely and against advice on a number of occasions and all agencies gave evidence of multiple missed appointments.

What is clear, now that agencies and information have been brought together in this Review is that, particularly in the last two years of his life, his risk had significantly increased, whilst at the same time the few protective factors of family and employment had disappeared.

Whilst it is uncertain how well Mr Arthur was known to his GP, records show he attended on several occasions in the last two years of his life. The General Hospital also reported that they always sent his GP a letter when he attended the Emergency Department (ED) and other hospital appointments. The GP notes describe him as having Korsakoff Psychosis and significant memory loss. Whilst these symptoms are not unusual in alcoholics, it may have suggested the need for additional support.

There were at least two recorded occasions when the insanitary conditions of his home were noted: firstly by the Police in July 2010 and secondly in June 2013 when a home visit from the Police found there was additional evidence of internal building structures being dismantled in the house. Police officers took action on that later occasion by informing the police Public Protection Unit of what they regarded as serious concerns. These concerns were subsequently passed to the Adult Social Work Service but were not pursued as a safeguarding matter.

Poor and insanitary living conditions may be regarded as an indicator of self-neglect, but whether this should require a formal safeguarding response, if the person has the capacity to make that decision and it is not harmful to any other person, remains a contentious matter. The social worker who dealt with the enquiry from the PPU, whilst taking action to suggest the police discuss with Housing Services, noted that, "*it may be that the gentleman in question is making an informed choice to live as he does*". As it appears that there was no information that he lacked capacity to make decisions this is a standard practice response.

- **Adequate assessment of capacity**

In order to identify whether he was an adult 'at risk' who was unable to protect himself and had need for care and support services, a holistic and comprehensive assessment was required. There is no record of such an assessment. Services he was offered seem to have been primarily to assist him in addressing his alcohol consumption or patching up the physical consequences of excessive drinking at ED and at The Shelter Trust.

The requirement by the Court for a Social Enquiry Report in May 2012 indicates that his underlying vulnerability and not just his overt criminal behaviour was beginning to receive some recognition by the Criminal Justice System. His deteriorating circumstances were evident from examining all agency chronologies, but the accumulation of difficulties was insufficiently known by all agencies.

Evidence for this deterioration is:

- increasing examples of his dirty and dishevelled appearance in public places;
- appearing confused and not recognising family members;
- experiencing fits to the point of unconsciousness;
- substantial short term memory loss indicating Korsakoff Syndrome;
- return of the Acoustic Neuroma and possible impact on his hearing, propensity to fall, and possible depression;
- 'upsetting' and consequently being at risk from other prisoners, when usually he was no problem in prison and had been described as a 'polite' man.

Mr Arthur's excessive drinking appears to have been seen as a choice and his mental capacity to make that choice and also to refuse service intervention, does not appear, or at least is not recorded as, being questioned.

Whilst it is recognised that the UK Mental Capacity Act is not a Statute in Jersey, the practice of assessing capacity of patients is well established in medical practice. Jersey uses other UK practice and guidance within its Health and Social Service Department. Under the Mental Capacity Act and using the Stage 2 process, Mr Arthur would have fitted the criteria for a capacity assessment, for example, on the occasions when he discharged himself from hospital against medical advice, he had impairment/disturbance in the functioning of his mind or brain and on occasion, this disturbance (appeared) to be sufficient that he lacked the capacity to make a particular decision.

There is no recorded consideration of capacity assessment by his GP. Such an assessment would have been likely to show that he did have decision making capacity in most areas of functioning, unless he was drunk or just in recovery from a significant bout of drinking, but it would also have given an opportunity to test out whether he had executive capacity i.e. could he carry out what he had decided to do? Importantly, a more formal approach to considering his capacity would have set a marker for future assessments and also demonstrated that professionals were monitoring his deteriorating condition.

The first principle of mental capacity assessments is that capacity should be assumed, and this is essential in upholding the human right of individuals to take risky and unwise decisions. However, workers always need to exercise professional, respectful, scepticism and ask themselves: i) do I have evidence that this person is able to both make a decision to do/not do this and, ii) can they carry out that decision and weigh its consequences? If they are uncertain then the activity of sensitive capacity assessment can protect the person, the worker, and their employing organisation.

- **Response to alcoholism**

There is a broad spectrum of views about the use and misuse of alcohol and whilst it is known that even small amounts of alcohol can alter people's perceptions and reduce inhibitions resulting in hazardous driving, risky sexual behaviour, street and domestic violence for instance, alcohol is highly valued for its relaxant and social lubricant qualities at personal and societal levels. The production and sale of alcohol also creates wealth for companies and individuals in the alcohol production and

sales industry as well as for governments maximising tax revenue. Alcoholism, however, is often perceived as a self-inflicted condition.

Levels of alcohol consumption are comparatively high in Jersey. In Europe the per capita (of population 15 years and over) consumption in 2013 was said to average 8 litres; in England the average was 10; and in Jersey it was 12.7. In 2003 this consumption was 16 litres, indicating some reduction in consumption.

"It is hard to gauge the true extent of addiction but recent surveys in Jersey suggest that at least 5% to 12% of people have some issues with hazardous alcohol consumption. It is estimated that approximately 4,000 out of a population of 99,000 people in Jersey are dependent on alcohol". (Ibid 27).

If Mr Arthur had been seen as being at risk because of his 'illness' (alcohol dependency and developing dementia), insanitary and ultimately unsafe living conditions; having regular falls; experiencing incontinence; also being socially isolated because of possible deafness; and possibly suffering from depression, engagement with him by agencies might have been quite different. The focus of support might have been assistance to improve his home conditions; assistance to manage his incontinence; social contacts and venues where his drinking could be 'managed'; and general support to manage the negative impacts of his heavy drinking.

Although, from previous experience, he may have refused that sort of support, there is no evidence that a general harm reduction programme was tried, because his problems were seen through the lens of alcoholism being his 'life style choice'.

1.3 **Conclusions**

The key questions, in addition to what we can learn from these events to improve practice, are whether Mr Arthur's death was predictable and more importantly was it preventable?

The review concluded that Mr Arthur's early death was predictable on general statistical grounds, relating to his long term and heavy consumption of alcohol. One controlled study of people who were alcohol dependent indicated that the average age at death was about 20 years younger than for the general population. (Cheers - *Mental Health Foundation 2006*).

Given that the actual cause of his death is unknown it is impossible to say if it was preventable. Some of the circumstances leading up to his death and the fact that his body was undiscovered for several months, were probably not preventable on the basis of his entrenched alcohol abuse and consequent social isolation. Even so, there are general grounds for thinking it might have been delayed by interventions to help him manage his drinking in a safer environment. However no such interventions took place and he was assumed to have capacity so no capacity assessment was considered, or at least recorded.

There were missed opportunities when agencies might have made a positive difference, and there are certainly lessons to be learnt from this Review that might prevent similar deaths or the possible suffering alone at the end of a life.

1.4 **Recommendations of SCR**

- Whilst it is recognised that most people who drink heavily retain capacity when they are not drunk to make their own decisions, professionals, who have contact need to be observant of behaviours that suggest judgement is becoming impaired when not drunk. Repeated high risk decisions, including leaving hospital against advice, self-neglect and/or self-harm, should trigger regular considerations for a mental capacity assessment using the UK Mental Capacity Act Guidance.

- The Safeguarding Adult Partnership Board (SAPB) needs to assure itself that its Safeguarding Procedures are clear that where a person making a contact (whether described as an alert, referral, concern etc.) with any agency with safeguarding responsibilities believes they are reporting a safeguarding matter that their concerns are thoroughly investigated. They should also receive timely feedback, including the reasons for no action being taken.

- Agencies with key safeguarding responsibilities should consider undertaking a practice audit of the handling of expression of concerns, Adult Protection Notices, Alerts, Referrals, most particularly where self-neglect and/or alcohol have been identified. They should seek to assure the Safeguarding Adult's Board that front line decision-making practice is taking account of the potential of the presence of alcoholism and self-neglect eclipsing considerations of adult protection assessment of capacity in decision-making.

- The findings of this SCR should inform the work currently taking place in Jersey on understanding and managing the challenges posed by adults at risk whose behaviour and/or circumstances suggest self-neglect and who refuse/avoid service interventions. This should include consideration of creating a case review list of people who would be contacted at regular intervals to check that their choices remain the same and involve some consideration that they continue to have the capacity to make the choice not to engage with support services.

- The Shelter Trust provided Mr Arthur with a degree of protection whilst recovering from his alcohol excesses. As he was not a homeless person and therefore not in need of The Shelter Trust's ongoing support, there was not an opportunity to get to know him. Consideration should be given to developing a non-statutory advice and ongoing support service to adults who are at risk due to the effects of their excessive alcohol use in public spaces but who are not in need of accommodation.

- People with identified health and care risks who regularly do not attend appointments should be identified as particularly vulnerable. If assertive action to engage them is unsuccessful any case closure should be based on a risk assessment and closure agreed with a senior/supervising staff member.

- The States of Jersey and the SAPB should consider, with the consent and possible involvement of Mr Arthur's daughter, how her letter could be used to work with offenders of alcohol related crimes to show the potential impact on the lives of their closest family members of their alcohol influenced behaviour.

- Given that alcohol abuse is a key area of personal and community risk in Jersey the SAPB should plan a programme of multi-agency training on identifying, treating, and jointly assessing and supporting people with Korsakoff syndrome and other alcohol related mental health disorders.

- Agencies should make a decision about the establishment of an integrated information technology system to capture information in respect of individuals' health, addictions, living circumstances and family support.

- The SAPB should assure itself that identifying and supporting victims of Domestic Violence, particularly at ED and in accessing accommodation is informed by current evidence about best practice.