Thematic Safeguarding Adult Review Overview Report

Learning from the deaths of George and Peter.

Commissioned by: The Keeping Bristol Safe Partnership.

Review Panel Chair and Report Author:

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1. Introduction

1.1 This Safeguarding Adult Review (SAR) has been commissioned by the Keeping Bristol Safe Partnership (KBSP) to extract the learning from the circumstances surrounding the deaths of two adults in Bristol between January and March 2024. Before their deaths, safeguarding concerns were raised about each person, particularly relating to self-neglect, engagement with services and their decision-making capacity.

1.2 The deaths were considered by the SAR/DHR Sub-Group of the KBSP in March 2024. The SAR/DHR Sub-Group recommended that both cases met the threshold for a SAR, this decision was subsequently ratified by the KBSP board.

1.3 The two adults subject of this SAR are both male, they were of a white British ethnicity. The two adults lived alone. George was 66 years old when he died, Peter was 70. Pseudonym's have been used for both subjects of this review.

1.4 George and Peter were known to a number of services prior to their deaths. This included health services, Adult Social Care, and Avon and Somerset Police. They both suffered from physical and mental ill-health and had significant issues with alcohol.

1.5 Under Section 44 of the Care Act 2014, a Safeguarding Adult Board, (SAB), must arrange for there to be a review of a case involving an adult in its area with need of care and support, (whether or not the local authority has been meeting any of those needs), if:

- There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions, worked together to safeguard the adult and
- the adult has died,
- and the SAB knows or suspects that the death resulted from abuse or neglect, whether or not it knew about the abuse or neglect before the adult died (the neglect includes self-neglect).

1.6 Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:

- identifying the lessons to be learned from the adult's case, and,
- applying those lessons to future cases.

2. The Purpose of the SAR

2.1 The purpose of a SAR is to promote effective learning and improvement to prevent future deaths or serious harm from occurring again. The purpose is not to apportion blame to any agency or individual.

2.2 The objectives include establishing:

- lessons that can be learnt from how professionals and their agencies work together
- how effective the safeguarding procedures are
- learning and good practice
- how to improve local inter-agency practice
- service improvement or development needs for one or more services or agencies.

2.3 The lessons learnt will be shared by the partnership to maximise the opportunity to better safeguard adults with care and support needs who may be at risk of abuse or neglect.

3. Terms of reference

3.1 To use a thematic review methodology to identify any learning, including examples of good practice, from George and Peter's cases.

3.2 To consider the learning that emerges in light of what is understood already through national research or published SARs.

3.3 To work with the SAR panel to develop agreed multi-agency recommendations and key actions for the KBSP board to consider.

3.4 The full terms of reference are at Appendix 4.

4. Methodology

4.1 The Care Act 2014 guidance states that the process for undertaking a SAR should be determined locally according to the circumstances of an individual case, no one model will be appropriate in all cases. The focus should be on understanding what happened and why, what may need to change and potentially, answers for the family and friends of the adult who has died or been seriously abused or neglected.

4.2 The KBSP have decided to use a thematic review methodology that engaged frontline practitioners and partner agency safeguarding leads. The review was facilitated by an Independent Chair and Overview Report author. Chronologies collated during the initial scoping phase, together with other relevant information, were reviewed by the Independent Chair to determine the appropriate areas for enquiry. Partner agencies were then asked to review their own involvement with George and Peter, and to provide a report detailing their involvement, good practice, learning, and suggested recommendations. A practitioner workshop was undertaken to consider the strengths of the current systems and to seek to identify potential areas for further improvement.

4.3 The Independent Chair then worked with the SAR panel to develop the overview report and agreed multi-agency recommendations for the KBSP Board to consider.

4.4 The panel agreed that the review would focus on the period between 1 January 2023 and George's death in January 2024. In Peter's case, the review focussed on the

period 1 January 2023 until his death in March 2024. Any relevant information relating to either subject from before these time periods was also considered.

4.5 The following agencies were identified as organisations who were involved in George and/or Peter's care and support. Each of those agencies completed a single agency independent management report and participated in the practitioner workshop event:

- Bristol City Council Adult Social Care, (ASC).
- Bristol City Council Housing and Landlord Services.
- University Hospital Bristol and Western NHS Trust, (UHBW).
- North Bristol NHS Trust, (NBT).
- South Western Ambulance Service NHS Foundation Trust, (SWAST).
- Bristol, North Somerset and South Gloucestershire Integrated Care Board on behalf of the GP practice, (GP practice).
- Avon and Somerset Police, (Police).
- Avon and Wiltshire Mental Health Partnership NHS Trust, (AWP).
- Bristol City Council Safer Communities.
- Avon Fire and Rescue Service, (AF&RS).
- Sirona care and health, (Sirona).
- Developing Health and Independence, (DHI)[1].
- LiveWest housing.

4.6 It was the responsibility of each participating agency to brief relevant managers and staff about the SAR, engaging them in the information gathering process and once completed, to brief them on the outcomes of the review.

4.7 Each agency was asked to nominate a person to act as the single point of contact for the review and additionally, where required, a designated person to undertake the single agency report.

4.8 The workshop was structured to enable specific issues relating to George and Peter's cases to be considered and then time allowed for focussing on broader themes identified in the review.

4.9 An important element of the SAR was to engage with George and Peter's families, to encourage their contribution to the process and then, to share the findings with them prior to publication. The Independent Chair sought to identify relevant family members for both subjects of this review and invite them to participate in the review process.

4.10 Chris Hogben, Invigor Consulting Ltd, was commissioned as the Independent Chair in respect of this review. He is completely independent from all of the agencies involved in this case.

5. Key Lines of Enquiry (KLOEs)

[1] DHI are no longer the provider in Bristol. On 1 April 2025, the provider changed to Bristol Horizons.

5.1 The following KLOEs were examined as part of the review. They are not in any order of priority. Agencies were requested to complete a single agency report, using an agreed Independent Management Review (IMR) template, addressing each area covering good practice, learning and where appropriate, recommendations against each.

5.2 **Alcohol Dependency**

- Was alcohol use identified as an issue?
- What services were available and offered to the adult?
- If not accessed, do you understand why?
- Was dual diagnosis recognised as an issue and if so, what strategies were considered to manage these issues?

5.3 **Self-Neglect**

- Was this identified as an issue?
- If so, what measures were taken to address this/support the adult?
- What services were available, (i.e. assertive outreach etc)?

5.4 **Mental Capacity**

- How well do practitioners understand and use mental capacity assessments?
- Do practitioners understand decisional and executive capacity?
- The impact of compulsive behaviours?

5.5 **Barriers to Engagement**

- What strategies were adopted to manage the adult's reluctance to engage with services with a focus on:
- Self-neglect, particularly where this relates to existing physical health concerns.
- The impact of compulsive behaviours.
- Non-engagement policy.
- Professional curiosity.

5.6 **Use of the Section 42 Framework**

- Was consideration given to using the Section 42 framework?
- Were adult safeguarding referrals made?
- What was the safeguarding response?
- How were risk management and safeguarding processes applied?

5.7 **Deteriorating Health Conditions including Mental Health**

- Were there physical health concerns and if so, what steps were taken to address them?
- Were there mental health concerns and if so, what steps were taken to address them?

5.8 **Domestic Abuse**

- Were practitioners able to identify domestic abuse?
- Did they have the skills and confidence to make referrals?
- Were referrals made with respect to domestic abuse?

5.9 **Exploitation including Financial Abuse**

- Did practitioners identify any form of exploitation, including financial abuse?
- If so, what steps were taken to address this and support the victim?

5.10 **Fire Risk**

- Did practitioners identify a risk of fire?
- If so, what steps were taken to mitigate the risk?

5.11 **Impact of the COVID-19 Pandemic**

- Although the agreed review period sits outside the dates of the COVID-19 restrictions, were services offered or provided by your agency affected due to the impact of the pandemic in 2020-2021?

6. Family Involvement

6.1 The Independent Chair wrote to Peter's adult son to invite him to participate in the review process. His son did not communicate with the Independent Chair. It was noted that the adult son had been estranged from his father, and indeed, subject of a protection from harassment order in favour of Peter. The review was not able to identify any other family members who might be able to participate in the review.

6.2 The review was not able to identify any family members who might be able to contribute to the review process with respect to George.

7. Narrative Chronology

7.1 Background Prior to the Review Period

George

7.1.1 George had been known to many services for a number of years prior to the review period. His first contact with AWP was in 2012 and he had extensive contact with their services almost every year from then through to 2023. Initially the contact related to low mood, depression, and suicidal ideation but it was noted that he already had issues with alcohol use in 2012 and was referred by AWP to drug and

alcohol services. He was referred to the Dementia and Wellbeing Service (DWS) on a number of occasions from 2017 but throughout his contact with that service, his alcohol use was seen as a barrier to being properly assessed for cognitive impairment. The DWS required patients to have a three-month period of abstinence from alcohol use prior to conducting a meaningful cognitive assessment. George was a dependent drinker and had declined to stop drinking. In 2021, he was assessed by the DWS who concluded that his cognitive impairment was secondary to alcohol-related brain injury and discharged him back to his GP.

7.1.2 George was known to ASC since 2018. George had extensive contact with ASC from 2018 which included support through a number of hospital admissions. He had a Care Act 2014 assessment in place and had been subject of a number of mental capacity assessments before the period subject of the review. George was also known to the police. Over the last few years of his life, his contact with the police was due to welfare checks and other calls related to his wellbeing and use of alcohol.

7.1.3 George had extensive contact with AF&RS from 2019. This included attending fires, Home Fire Safety Visits (HFSVs), and attending multi-agency meetings. Key concerns related to George's use of alcohol, his cognitive impairment, and the fact that he was a heavy smoker, all of which created a significant fire risk. There was no contact from May 2021 until a fire in June 2023.

Peter

7.1.4 Peter was known to AWP from 2016 when he was admitted to hospital following a fall and injuring his head. He was identified as being alcohol dependent but was not diagnosed as being mentally unwell. He was first referred to the DWS in 2021. Due to what was described as his severe alcohol dependency, the DWS were unable to assess him and discharged him back to his GP until such time as his alcohol use reduced to 14 units or less per week.

7.1.5 Peter was assessed by the AWP Later Life Psychiatric Liaison Team (LLMHT) in December 2022, following a referral from the Acute Trust. He was assessed as having significant cognitive impairment and that a complex discharge process would be required due to concerns about Peter being able to care for himself, potential falls, alcohol use, and the risk of exploitation.

7.1.6 Peter had contact with ASC from 2017. As with George, Peter had a significant amount of contact with ASC practitioners and had a Care Act 2014 assessment in place. He had also been subject of a number of mental capacity assessments.

7.1.7 Peter was known to Avon and Somerset Police since 2006. He was recorded as the perpetrator for domestic abuse and had served time in prison for his offending. He was also recorded as the victim of abuse with his son as the perpetrator. As a result of the abuse from his son, a protection from harassment order preventing his son from contacting Peter or going to his address, was in place. Initially this would have expired in 2022, but it was extended to June 2025.

7.2 **The Relevant Period**

7.2.1 The narrative chronology for both George and Peter are attached as Appendix 2 and 3 respectively to this report. A summary of the chronological entries is provided below:

George

7.2.2 George had been admitted to hospital shortly before the review period commenced and was not discharged until late March 2023. There were a number of agencies involved in the discharge planning and as George was assessed as lacking the mental capacity to make decisions about his discharge, an Independent Mental Capacity Advocate (IMCA)[2], was appointed for him. The IMCA made it clear that George wanted to be discharged to his home address, and despite concerns about his use of alcohol and his ability to keep himself safe, he was discharged with an agreed package of care and support in place.

7.2.3 Having been discharged to his home address, agencies who had contact with George began raising concerns about his mental health, alcohol use, self-neglect, and the risk from him smoking cigarettes. It was already known that he suffered from alcohol-related cognitive impairment.

7.2.4 George started drinking heavily following his discharge from hospital in late March 2023 and the contact that services such as the police, SWAST, ASC, and AF&RS had with him primarily related to issues arising from his use of alcohol. George was also suffering from mental-ill health and self-neglect. He was referred to DWS, but he was discharged back to the GP due to the level of alcohol that he was using.

7.2.5 George's use of alcohol escalated further in the second half of 2023. A number of safeguarding referrals were made by the professionals who had contact with him, primarily about his alcohol use, self-neglect, and his lack of capacity to make decisions. It was also noted that George was often quite aggressive when he had been drinking; he did not always engage well with his carers or support workers.

7.2.6 George was provided with support to try and manage his alcohol use by Supported Independence practitioners; their support was increased to daily, seven days a week. They provided 'outreach support' to George to try and improve his engagement with the service.

7.2.7 As well as his use of alcohol, George had a significant cognitive impairment and was considered by many practitioners to lack capacity for many decisions.

7.2.8 George was subject to a formal assessment by AWP; they assessed that there was no evidence of acute clinical depression or acute psychosis. He was described as having declining cognitive function, presenting as being at risk of falls and as lacking

[2] An Independent Mental Capacity Advocate is an advocate who can act for a service user if they lack capacity to make certain decisions and they do not have family or friends to represent them.

insight into his care needs. The assessment stated that George lacked the capacity to make decisions regarding his care and treatment.

7.2.9 AF&RS completed a HFSV in late October. Fire retardant spray was used on George's bed where burn marks were identified. In December, concerns were raised with the social worker about George urinating in the communal areas outside his flat and burning the carpets with cigarettes. Although the social worker contacted Supported Independence to ask if they were aware of the issues, there was no referral to AF&RS to mitigate the fire risk.

7.2.10 The social worker subsequently arranged a joint visit to see George with an occupational therapist on 17 January. George was rescued by AF&RS from his flat on 11 January following a fire in the premises. Sadly, George died in mid-January.

Peter

7.2.11 Peter was assessed by the AWP LLMHT in January 2023. The assessment concluded that he suffered from cognitive impairment and that alcohol was a likely major causative factor. He was discharged with his existing care package in place.

7.2.12 During January and February, the agencies who had contact with Peter recorded that he was often confused and was drinking alcohol excessively. On 26 February, Peter was taken to hospital by SWAST following a suspected head injury. He remained in hospital until he was discharged on 2 March. Hospital staff submitted a safeguarding referral after taking advice from the hospital safeguarding team. Information was shared with the GP by the hospital and SWAST.

7.2.13 During March, concerns were raised by the police about Peter's drinking and potential financial exploitation by females staying at the address. This was supported by a SWAST crew on 2 April, who also raised concerns about financial exploitation and potential cuckooing. Both the police and SWAST submitted safeguarding referrals to ASC.

7.2.14 On 7 April, SWAST attended Peter's address and documented a mental capacity assessment. Peter was assessed as lacking the capacity to make a decision about being taken to hospital. He was conveyed to hospital and remained there until discharged five days later. The UHBW records document that Peter was referred to the specialist alcohol nurse to try and address his alcohol use.

7.2.15 Throughout the rest of April and May, services continued to have regular contact with Peter. Concerns about his cognitive impairment, use of alcohol and potential exploitation were raised by the police and SWAST. When SWAST had taken Peter to the emergency department (ED) on 14 May, the UHBW staff referred him to the specialist alcohol nurse.

7.2.16 During late May and early June, the police and the GP had contact with Peter. The concerns remained the same, the GP also recorded concerns about Peter's mental

capacity. The police recorded a conversation with Peter about Female A where he informed them that she was his girlfriend.

7.2.17 In the afternoon of 11 June, AF&RS attended a call to a fire alarm and the smell of burning at Peter's address. Peter was found asleep in the living room. He was conveyed to ED, by SWAST. Peter was unharmed but UHBW referred him to the specialist alcohol nurse. It was noted that there were considerations documented about using an IMCA advocate but there was no record of a mental capacity assessment being completed. SWAST shared information about this incident with the GP and the GP made a safeguarding referral to ASC regarding self-neglect.

7.2.18 The following day, AF&RS raised an internal alert due to the concerns about a fire risk, and this led to a request for a HFSV. They also made a referral to Bristol ROADS[3]. The HFSV did not take place as AF&RS were unable to contact Peter.

7.2.19 On 17 July, SWAST conveyed Peter to the ED following concerns about a fall and a possible head injury. The SWAST crew documented a mental capacity assessment which determined that Peter did not have the capacity to make a decision about going to hospital for treatment. He was assessed as having no obvious injuries, a chronic alcoholic, confused and at risk of malnutrition. He was admitted for observation and discharged on 24 July. A safeguarding referral was made to ASC as UHBW had concerns about Peter's living conditions and his ability to keep himself safe. A discharge letter was sent to the GP practice raising the same concerns.

7.2.20 During August, a number of attempts were made by Developing Health and Independence (DHI)[4] to contact Peter to arrange a meeting to consider support with respect to his dependent drinking. After two left voicemails and two text messages, the referral was closed on 14 August.

7.2.21 On 31 August, following a further Bristol ROADS referral from AF&RS, DHI contacted Peter and arranged an assessment appointment for 7 September. Peter did not attend the appointment on 7 September or the rescheduled one for 13 September, so he was discharged from the service.

7.2.22 Between mid-September and the end of December, agencies continued to have contact with Peter with concerns about his cognitive function, alcohol use, and potential exploitation. Although agency records document those concerns, it was noted that safeguarding referrals were not submitted. There was a cross-agency strategy meeting held on 31 October to consider Peter's mental capacity, alcoholism and the risk of financial abuse. The review could not identify what actions were agreed at this meeting.

[3] Bristol Roads---(Bristol Recovery Orientated Alcohol and Drugs Service), provide support to help adults reduce the harm from alcohol and drugs. Their service includes both outreach and in-reach services. Whilst correct for the time period subject to this review, the service is now provided by Horizons.

[4] DHI were a partner in Bristol ROADS, (Recovery Orientated Alcohol and Drugs Service).

7.2.23 On 15 December, the police dealt with an incident at Peter's address involving a cut to Female B's hand. Peter was recorded as being in a disheveled state. A safeguarding referral was submitted to ASC.

7.2.24 During January and February 2024, the police, SWAST, and the GP had contact with Peter. SWAST recorded a mental capacity assessment on one occasion, deeming Peter to have capacity to decline to go to hospital. The police spoke to him about exploitation concerns, but he denied this. A safeguarding referral was submitted to ASC.

7.2.25 On 8 February, the GP tried to contact Peter by phone, but it was answered by a female. The phone was handed to Peter, but he declined to speak to the GP. A home visit was planned for the following week as the GP was concerned about Peter's capacity, home environment, and confusion. This was good practice as Peter had not attended a number of appointments during the period subject to the review.

7.2.26 The home visit was carried out on 15 February. The GP assessed that Peter had capacity although what decisions this was for was not recorded. A female present was described as Peter's girlfriend. As Peter was known to be open to ASC, the GP did not make any referrals.

7.2.27 On 29 February, Peter was found unconscious by SWAST and conveyed to Southmead hospital. Despite medical interventions, he sadly died in mid-March.

8. Findings and analysis

8.1 Alcohol Dependency

8.1.1 It is clear throughout the narrative chronologies, that alcohol use was a key issue in the lives of George and Peter. Both men were identified as dependent drinkers but there was a significant difference in how their alcohol use was managed.

8.1.2 In George's case, his use of alcohol was clearly identified by practitioners. George had been admitted to hospital in December 2022, prior to the period subject of this review. There were concerns raised that George would start drinking again when discharged from hospital in March 2023. Bristol City Council Housing and Landlord Services documented that George was confused and angry in their contact with him less than two weeks after his discharge, as he wanted alcohol. It was clear to the review that George had a significant level of support post discharge, this included support from Supported Independence with respect to alcohol use.

8.1.3 George's use of alcohol became more problematic in the second half of 2023. There were a number of incidents reported where George was drunk and confused between August and October. In November, Supported Independence began providing outreach plus services for George, with contact raised to daily home visits, seven days a week.

8.1.4 Ward and Preston-Shoot (W and PS) provide guidance in their safeguarding dependent drinkers report (2020)[5]. They describe dependent drinkers who are not only hard to engage with but are also vulnerable and have a significant impact on public services. W and PS make a number of key points; firstly that the Care Act 2014 does apply to people with alcohol problems, they also remind professionals that it is a misconception that dependent drinkers are making lifestyle choices, alcohol dependency, as with drug addiction, is a compulsive behaviour and should be considered when assessing an individual's mental capacity, particularly their executive capacity (their ability to not only understand the decision in the abstract but to know when to put the decision into effect and the ability to execute it). The research identifies that dependent drinkers are often difficult to engage with, or they refuse to accept services offered. They suggest commissioning alcohol services that meet the needs of clients through persistent, assertive services built on relationship building, harm reduction, and motivational interventions.

8.1.5 In George's case, the use of outreach support to try and engage with him as a dependent drinker and address his alcohol use would be seen as good practice. The impact of a compulsive behaviour on the ability of a service user to engage with services and the potential impact on mental capacity are explored later in this report.

8.1.6 In Peter's case, he had a long-term problem with alcohol use. He had been assessed in early January by the AWP LLMHT, and it was determined that his alcohol use was likely to be a major cause of his cognitive impairment.

8.1.7 Agencies had significant and regular contact with Peter throughout the period subject to the review, a common feature of that contact was Peter having been drinking alcohol and often being described as intoxicated. What is less clear, are the steps taken to address the risks Peter faced due to his alcohol use.

8.1.8 Whilst in hospital for separate admissions in both April and May 2023, Peter's alcohol use was identified as an issue by practitioners. In both cases, the UHBW records documented that he was referred to the specialist alcohol nursing team although there was no record of the outcome of the referrals.

8.1.9 In June, AF&RS dealt with a fire at Peter's address, the fire had started whilst he was preparing food. He was recorded as having been 'intoxicated' at the time. He was conveyed to hospital where the UHBW records again documented that he was referred to the specialist alcohol nursing team. Whilst the referrals are good practice, it was noted that there was no documented record of the outcome of the referral.

8.1.10 In June and August, AF&RS made referrals to Bristol ROADS with respect to Peter's alcohol dependence. After the first referral, DHI attempted to contact Peter. After leaving two voice mails and sending two text messages, DHI closed the referral. Following the second referral, DHI contacted Peter and arranged an appointment for

[5] 'Safeguarding Vulnerable Dependent Drinkers England and Wales', (2020),-Mike Ward and Professor George Preston-Shoot. https://www.saeb.org.uk/wp-content/uploads/2022/10/safeguarding-vulnerable-dependent-drinkers.pdf

7 September. Peter did not attend the appointment or the rescheduled one. The referral was closed.

8.1.11 The GP reviewed Peter's use of alcohol at a face-to-face appointment in November. Peter was offered a referral to Bristol ROADS, but he declined it.

8.1.12 The review also noted that the police records documented that both George and Peter suffered from alcohol-related dementia. The police had contact with George and Peter on occasions and alcohol use was identified as an issue. The police did not make any referrals to drug and alcohol services, or sign post them to support services, with respect to either subject. It was recognised that there is no direct referral pathway for substance use available to the police. Substance use concerns would be raised through safeguarding referrals to ASC or health agencies.

8.1.13 The practitioner event considered the challenges that managing dependent drinkers present to professionals. Some agencies were unsighted on the substance use support services that were available or the referral pathways to access them. The issue of fluctuating mental capacity was raised and the lack of consent to share information with some adults. This was particularly relevant to alcohol use referrals because adults needed to want to engage with the service offered. It was also noted that dependent drinkers present very differently whilst in hospital where they are sober and in a good environment. When they are discharged, they go to their home environment and invariably, start using alcohol again.

8.1.14 Practitioners reflected on the additional challenges of managing dependent drinkers such as George and Peter who were diagnosed as having alcohol related cognitive impairment. When referred to the DWS, they were discharged back to their GP as the DWS would not accept adults unless they had been abstinent from alcohol use for three months. Attendees believed that both George and Peter would have benefitted from some of the services offered by the DWS.

8.1.15 The review reached out separately to DWS who confirmed that they do require abstinence from alcohol for three months or at least, a reduction in alcohol use to under 14 units per week before accepting adults into their service. The main reason being that any cognitive testing or functional assessment will not reflect that person's cognitive ability whilst they are substance dependent. Dementia is an umbrella term for progressive, irreversible conditions such as Alzheimer's disease and Huntington's disease. An adult suffering from cognitive impairment caused by long term alcohol use may fully or significantly recover when abstinent from alcohol.

8.1.16 DWS did confirm that there were some cases where DWS may consider an assessment for dementia even where abstinence from alcohol cannot be achieved. Primarily this may be where the adult has developed alcohol dependence more recently and there are grounds to suspect that dementia co-exists with dependent drinking. There is therefore some flexibility in the pathway where DWS may accept

an adult for assessment where alcohol use below the recommended limit can be achieved for three months[6].

8.1.17 It was noted that George and Peter, like many alcohol related dementia sufferers, did not have any supportive networks around them. Practitioners reported that in their experience, long term users of alcohol had often damaged and probably severed relationships with family members due to their excessive alcohol use.

8.2 Self-neglect

8.2.1 An analysis of SARs between 2017 and 2019[7] found that 45% of SARs commissioned in England related to self-neglect. However, despite the learning that was identified through those reviews, self-neglect remains a key issue for SABs. This review considered the identification of self-neglect in George and Peter's case and practitioners' response to the risk presented.

8.2.2 Self-neglect is often challenging for practitioners for a number of reasons:

- The varied presentations which can include a complex mix of personal, mental, physical, social and environmental factors.
- The potential challenges of engaging with the individual who may not welcome interventions or support.
- The challenge of respecting the individual's right to self-determination whilst meeting the requirements of a duty of care.
- Mental capacity assessments.
- Identifying the high level of risk in relevant cases.

8.2.3 In both George and Peter's cases, practitioners had submitted a number of safeguarding referrals, some of which related to self-neglect.

8.2.4 George was not able to manage his hygiene needs and declined to accept support from the care staff during the review period. He would often refuse the carers entry to his flat or, if they were allowed into the flat, he wouldn't cooperate with them. Practitioners from different agencies identified the risk of self-neglect and made safeguarding referrals to raise their concerns. It was noted that when assessed by AWP in September 2023, it was determined that George lacked insight into his own care needs and lacked the mental capacity to make decisions regarding his health and treatment.

8.2.5 There were six safeguarding referrals made during the review period for Peter, three of the referrals raised concerns about self-neglect, although one of these referrals also related to a fire risk and a plan was in place to mitigate the risk. The review

[6] Alcohol related brain damage (ARBD) is not dementia. It is regarded as a fixed cognitive impairment that will eventually be irreversible but often, particularly in the early stages, can be fully reversed, or partially reversed through abstinence from alcohol, a good diet and vitamin B replacement. (RCPsych 2014 college report on ARBD).
https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr185.pdf?sfvrsn=66534d91_2

[7] Preston-Shoot, Braye et al, Analysis of Safeguarding Adult Reviews April 2017-March 2019. (2020).

noted that Peter was assessed in July 2023 by UHBW practitioners when he attended the ED. He was described as a chronic alcoholic, at risk of malnutrition, and there were concerns about his home living conditions. This would appear to be identifying the risk of self-neglect. A safeguarding referral was submitted.

8.2.6 In December 2023, the police submitted a safeguarding referral after attending Peter's address. He was described by officers as being dishevelled and did not appear lucid. With Peter's history, this would appear to raise concerns about self-neglect.

8.2.7 The review noted that there was limited recognition of the risk of self-neglect with respect to Peter despite his difficulties with self-care and alcohol abuse. The GP records documented that his medical record was coded with a 'self-neglect' warning in 2019 but that was closed later the same year. There were no self-neglect concerns identified by the GP for Peter. The UHBW's documentation of self-neglect concerns was limited. Furthermore, the lack of consistent safeguarding referrals being submitted may suggest limited awareness or gaps in the protocols for managing patients with self-neglect and associated vulnerabilities. It was also noted that SWAST records documented that although Peter was recognised as being vulnerable and safeguarding concerns were raised for him, self-neglect was not specifically identified.

8.2.8 The practitioner event focussed on professionals identifying the risk of self-neglect and the need to make safeguarding referrals when appropriate. It was recognised that the safeguarding risk to children was readily identified by practitioners and subject to safeguarding referrals. However, where cases involved adults with safeguarding needs, particularly self-neglect, this was not always the case. Attendees suggested that respecting the wishes of the adult and the issue of 'lifestyle choices' may impact on decision making as well as understanding the threshold of when self-neglect becomes a safeguarding matter. This is explored further at section 8.5 of this report (Use of the Section 42 framework[8]).

8.2.9 The review noted that alongside the MASH[9], ASC had invested in a safeguarding advice line which operates now between 0830 and 1700 on weekdays. This provides access for practitioners to an experienced social worker who can provide advice and guidance on adult safeguarding matters. This would clearly include advice on safeguarding in self-neglect cases. The review considered this to be good practice, although it was noted, that many practitioners were not aware of the existence of the safeguarding advice line which would suggest that this resource could be advertised more widely.

8.3 **Mental Capacity**

[8] Section 42 of the Care Act 2014 states the duty of the Local Authority to cause enquiries to be conducted where an adult has care and/or support needs, is at risk of abuse or neglect and is unable to protect themselves from that abuse or neglect.

[9] Multi-Agency Safeguarding Hub.

8.3.1 Assessing mental capacity is a significant challenge for practitioners involved in safeguarding and carrying out their responsibilities under the Care Act 2014. The wording of the Mental Capacity Act 2005, namely '*A person is not to be treated as unable to make a decision merely because he makes an unwise decision',* is often misconstrued by practitioners as meaning that people have a right to make unwise decisions. Professor Preston-Shoot and others, in their paper 'Effective work with adults who self-neglect' (2020), advise us that capacity is decision specific and time specific. '*A person lacks capacity if they have an impairment or disturbance in the functioning of the mind or brain, as a result of which they are; unable to make the decision, unable to understand, retain, use or weigh relevant information or communicate the decision'.* The report describes the need to include both 'decisional capacity and executive capacity' to assess capacity. Specifically, this means that when working with self-neglect, practitioners should not only consider the person's ability to understand and reason through the elements of a decision in the abstract, but they also need to consider the person's ability to realise when a decision needs to be put into practice and to execute it at the appropriate moment.

8.3.2 Furthermore, when considering executive capacity, W and PS emphasise the fact that addiction may impair a person's executive capacity, particularly their ability to weigh and use the information. Compulsive behaviour could also include self-neglect.

8.3.3 In Peter and George's cases, the use of mental capacity assessments appears to be inconsistent and there is no documented evidence of compulsive behaviours being considered within them.

8.3.4 The ASC records document that there was one mental capacity assessment[10] formally recorded for each subject of this review. In George's case, this related to how his care and support needs should be met. The social worker concluded that George did not have capacity for the decision due to a limited ability to retain information. It was noted that there was no consideration of executive capacity or a recorded associated 'best interest' process. In Peter's case, it related to his ability to manage his finances. It concluded that Peter was not able to weigh up information for this decision. There was good evidence that executive capacity was also considered. The social worker's rationale for determining that Peter did not have capacity was recorded and well-reasoned. There was however, no recorded 'best interest consideration'.

8.3.5 George's medical record documents that he was subject of a formal mental capacity assessment whilst in hospital in March 2023. He was deemed not to have capacity for discharge decisions and there was involvement of an IMCA which would be seen as good practice. Although at times, practitioners expressed concerns about George's capacity to make decisions; there was a lack of documented evidence of formal mental capacity assessments being recorded. The review noted that when

[10] A useful guide to carrying out and recording mental capacity assessments was produced by 3 Essex Chambers in March 2023. It can be found at https://www.39essex.com/sites/default/files/2023-03/Mental%20Capacity%20Guidance%20Note%20Capacity%20Assessment%20March%202023.pdf

George was assessed by AWP in September 2023, it was determined that George lacked insight into his own care needs and lacked the mental capacity to make decisions regarding his health and treatment.

8.3.6 Peter was subject of a number of mental capacity assessments by SWAST practitioners. In April and July 2023, SWAST practitioners recorded mental capacity assessments that deemed that Peter did not have capacity to decline to go to hospital. In January 2024, the SWAST crew documented that Peter did have capacity to refuse to go to hospital. A few weeks later, in February, the GP completed a home visit and determined that Peter had capacity for health-related decisions albeit the rationale for this was not recorded.

8.3.7 The UHBW records did not reflect a consistent use of formal assessments of Peter's mental capacity despite his presentations which frequently involved confusion, intoxication, self-neglect and behavioural changes. The inconsistency may suggest that staff may have lacked the level of knowledge and skills in identifying capacity issues, undertaking mental capacity assessments or recognising concerns and implementing legal protections.

8.3.8 Attendees at the practitioner event were confident that most practitioners could complete a basic mental capacity assessment or have access to colleagues who could support them in carrying out assessments where required. Those professionals attending the event were less confident that practitioners understood the best interest principles and the need to properly document these considerations. It was agreed that this appeared to be a learning gap for the process.

8.3.9 LiveWest provided housing for Peter as a tenant. Although there were concerns raised about the use of alcohol, there were no concerns about Peter's mental capacity. The review noted that LiveWest's practitioners do not have any mental capacity training or awareness as this was not considered a necessity. The review recognised that this may create challenges for the agency when dealing with adults who may not be deemed by other professionals to have the mental capacity for decisions relating to housing or financial matters. This was the case for Peter who was a tenant of LiveWest throughout the period subject of this review.

8.3.10 This issue was considered by the practitioner event which recognised that LiveWest have a safeguarding team who provide advice and guidance for public facing practitioners. Where there were concerns about a client's ability to engage with the service or to make a decision, practitioners would refer the matter to the safeguarding team.

8.4 Barriers to engagement

8.4.1 Services had significant and regular contact with George and Peter but their engagement with those services was inconsistent. The review recognised the level of support offered to both adults by practitioners during the period subject of this report and the investment of time to try and engage with them.

8.4.2 The GP records document that there was a code on George's medical record to highlight a potential learning difficulty and that he was unable to read or write. The GP noted that he rarely sought medical help for himself, contact was usually initiated by his carers. The GP practice had adapted access to services for him by enabling the carers or support workers to contact the practice on his behalf, this was seen as good practice.

8.4.3 Peter's GP documented that there were challenges in engaging with him through either online or digital communications. Although the surgery used text messages to send reminders and prompts for appointments, Peter often did not attend appointments. Peter was able to engage in health reviews when supported to attend face-to-face appointments and, on occasion, by telephone.

8.4.4 Both adults were rightly identified to be dependent drinkers by most agencies who had contact with them. As discussed in section 8.1 of this report, research suggests that dependent drinkers are often difficult to engage or refuse to accept services offered. George and Peter did not engage with some services, and it seems likely that their dependence on alcohol may have been a key factor in this.

8.4.5 George resumed his use of alcohol after being discharged from hospital in March 2023. He received support from Supported Independence and, in October 2023, outreach support, to try and better engage with him as a dependent drinker and address his alcohol use. This was seen as good practice.

8.4.6 In Peter's case, his use of alcohol is likely to have impacted on his ability to engage with services but practitioners also experienced challenges with two females who were frequently at his address.

8.4.7 Professionals sought to make referrals to DHI for Peter to address his alcohol use during 2023. On the first occasion, after leaving two voice messages and two text messages the referral was closed. On the second occasion, two appointments were made and as Peter did not attend, the referral was again closed. Whilst this may be in line with the DHI policy, the review questioned whether there should be a greater degree of investment to engage with dependent drinkers, particularly those who self-neglect, who are recognised as adults that are difficult to engage with. In George and Peter's cases, they were also considered to lack mental capacity.

8.4.8 The relationship that Peter appeared to have with two females, Female A and Female B, may have impacted on the ability of practitioners to engage with Peter. This was recognised by practitioners but there is limited recorded evidence of steps taken to address this. This is further explored within section 8.8 of this report.

8.4.9 The use of assertive outreach teams, investing time and resources to develop a 'relationship' with those individuals who do not wish to engage with services, is recognised as good practice (Preston-Shoot et al)[11], particularly where self-neglect is an issue. In George's case, the use of assertive outreach was utilised to try and

[11] Professor Preston-Shoot et al, 'effective work with adults who self-neglect', (2020).

address his dependency on alcohol. It also helped to encourage him to accept and cooperate with his care and support package. There is no record of any consideration of assertive outreach to try and improve the engagement with Peter.

8.4.10 The practitioner event looked at potential barriers to engagement for service users such as George and Peter. The 'episodic' nature of the contact many agencies have with service users provides little or no opportunity for relationship building. This will often involve different practitioners interacting with the service user each time they have contact with a specific service. This was particularly relevant to the police, hospital staff, and ambulance crew members. Others, such as the GPs, were able to provide a greater continuity in terms of the professional involved but were hampered by limited time slots with each patient. The review noted that the GP invested time to carry out a home visit with Peter to better understand the environment he lived in, which was seen as good practice.

8.4.11 Practitioners also raised the challenges of building a relationship with a service user when a number of professionals were involved in a case, particularly if the adult has complex needs. As well as agreeing with the value of face-to-face appointments when dealing with adults with complex needs, the practitioner event also discussed the consideration of using advocates to try and better engage with adults such as George and Peter. In George's case, an IMCA was used to support George to be involved in his care planning in early 2023. However, practitioners identified that an advocate could have been used to try and improve the limited engagement with both adults. This would have enabled communication to be channeled through one contact point which may have enabled the adult to engage more effectively with the services offered. The practitioner event recognised that the MASH was reported to be actively encouraging referrals for the use of advocates in relevant safeguarding scenarios, either as IMCAs or advocates appointed in line with Section 67[12] of the Care Act 2014.

8.5 Use of Section 42 Framework

8.5.1 The review noted many examples of good information sharing, including through the submission of safeguarding referrals by practitioners. Information was shared with the GP practices by other health professionals and the police submitted a number of safeguarding referrals during the period under review.

8.5.2 Although there were examples of good information sharing and a significant number of safeguarding concerns raised, agencies generally worked in silos in their contact with George and Peter. Although agencies submitted safeguarding referrals, there was no single agency who appeared to understand the holistic risk picture around either of these adults, no cross-agency plan to mitigate that risk and no identified agency who had clear ownership of leading the response to the risks that George and Peter faced.

[12] Section 67 of the Care Act 2014 sets out the duty of the local authority to appoint an advocate to support service users in certain circumstances.

8.5.3 As a result, some agencies had limited understanding of the risks that both adults faced. Although most agencies recognised the risk of alcohol use, others did not identify the risk of self-neglect. Whilst both Peter and George were subject of mental capacity assessments by some agencies and deemed not to have capacity to make specific decisions, other agencies assumed that they had capacity to make decisions with respect to their care and treatment. LiveWest, who provided housing services to Peter, reported that they were not aware of any safeguarding concerns with respect to him. A more joined up approach may have enabled George and Peter's care and support needs to be better met.

8.5.4 The review recognised that there was evidence of multi-disciplinary meetings in the case of both adults, and there was a multi-agency meeting in October 2023 in respect of Peter. However, there was no record available to the review of any consideration of using the Section 42 framework in line with the Care Act 2014 to bring agencies together and provide a joint response to the risk in George and Peter's cases.

8.5.5 Section 42 of the Care Act places a statutory duty to cooperate on agencies, initiating cross agency information sharing, a better-informed risk assessment, and enables a multi-agency risk management plan to be implemented. The criteria for a Section 42 enquiry are:

- Were there reasonable grounds to suspect that the adult has care and support needs?
- Were they at risk of abuse or neglect? (Neglect would include self-neglect).
- Does the adult have ability to protect themselves from the abuse or neglect? (Where this relates to self-neglect, the statutory guidance is termed as 'the ability to protect themselves by controlling their own behaviour').

8.5.6 It was recognised that George and Peter had care and support needs, and indeed there were care and support packages in place to try and meet these needs. In George's case, he was at risk of self-neglect, this was identified by some agencies and subject of safeguarding referrals. Peter was identified as being at risk of self-neglect in some safeguarding referrals, but he was also identified as being at risk of abuse, particularly financial abuse. In both cases, the two adults clearly met the criteria under the first two points.

8.5.7 Having determined that both George and Peter had care and support needs, and that they were at risk of self-neglect, and in Peter's case, abuse, the final element to be satisfied would be whether they were able to protect themselves from the self-neglect or abuse. Both adults' substance use would be considered a compulsive behaviour and as discussed in section 8.3 of this report; compulsive behaviours are recognised as potentially impacting on an individual's ability to put a decision into practice. The addiction to alcohol would be likely to also have an impact on George and Peter's ability to protect themselves from self-neglect by controlling such behaviour. In both cases, the adults also had issues with mental capacity and with

cognitive impairment. This would also impact on their ability to protect themselves from self-neglect, or in Peter's case, from abuse as well.

8.5.8 Having considered each of the elements based on the information available to agencies, it would be reasonable to conclude that the threshold for a Section 42 enquiry, in line with the Care Act 2014, was met in both cases. This view would be supported by Ward and Preston-Shoot in their safeguarding dependent drinkers report (2020). They conclude that the Care Act duty would apply to dependent drinkers. They also remind professionals that it is a misconception that dependent drinkers are making lifestyle choices, alcohol dependency, as with drug addiction, is a compulsive behaviour and should be considered when assessing an individual's mental capacity, particularly their executive capacity. As well as creating care and support needs, this would impact on their ability to protect themselves from abuse or neglect, including self-neglect.

8.5.9 The practitioner event determined that the criteria for a Section 42 enquiry would have been met for both Peter and George's cases. Both George and Peter were in receipt of care and support packages, and it seemed likely that practitioners may have seen that as an alternative to safeguarding rather than being part of the safeguarding process. It was also noted that the MASH is a multi-agency structure with a number of safeguarding agencies participating. This is seen as good practice and enables safeguarding referrals to be considered holistically with more effective information sharing.

8.5.10 The fact that the formal Section 42 framework was not used was a missed opportunity to bring agencies together under the statutory duty to cooperate, to develop a holistic view of the risk that both George and Peter faced and to agree a cross-agency plan to mitigate that risk. This may have enabled his care and support needs to be better met.

8.6 Deteriorating Health Conditions including Mental Health

8.6.1 George and Peter had significant physical health needs and had regular contact with health services. In both cases, their cognitive impairment and ongoing alcohol abuse had a negative impact on the ability of health professionals to treat their health needs.

8.6.2 George had a number of physical health concerns, which included poor mobility, frequent falls, urinary incontinence, memory impairment, hepatitis C and liver cirrhosis. The GP found engaging with George about his physical health very challenging. It was also difficult to ensure that he used his medication properly. The GP engaged with George's support worker to aid compliance. George was prescribed a significant number of medications which have not been specifically listed within this report. It was noted that the GP had carefully documented medication reviews and the medication discussions with other professionals who were involved in George's care and support. This was seen as good practice.

8.6.3 There were concerns about George's mental health and wellbeing throughout the period subject to the review. George was referred to mental health services but was considered to not have been suffering from a mental illness. He was also referred to the DWS. The DWS discharged George back to his GP, recommending a mental health assessment and a referral to the recovery service. George was subject of a further mental health assessment in September 2023. The AWP practitioner determined that there was no evidence of clinical depression or acute psychosis. They commented on his declining cognitive function and his lack of insight into his care needs. He was also assessed as lacking mental capacity to make decisions about his care and treatment.

8.6.4 Although the focus of health practitioners in 2023 was primarily on Peter's deteriorating health in relation to his cognition and alcohol addiction, he had a number of other health issues. In 2022 he had suffered a stroke, had a history of head injuries, and had been diagnosed with coronary artery disease. His medical records document that he was unable to take the normal medications for these issues due to his risk of falls and haemorrhage, secondary to persistent alcohol intoxication.

8.6.5 Peter was reluctant to engage with health services on occasions and was also recorded as being intoxicated at other times. This made assessments difficult. An example being the Sirona falls team in October 2023 where he presented as intoxicated when they carried out an assessment during a home visit.

8.7 **Domestic Abuse**

8.7.1 There was no evidence available to the review to indicate that George was either a victim or perpetrator of domestic abuse during the period subject to this review.

8.7.2 Peter was recorded as the victim of domestic abuse prior to the period subject of the review. The perpetrator of abuse was Peter's son. This had been dealt with appropriately and it was noted that there was a protection against harassment order in place to prevent his son from having contact with his father, Peter.

8.7.3 During the period subject to the review, there were concerns raised about Peter potentially being a victim of exploitation with one of two females being the perpetrator. Several agencies recorded females by the name of Female A and Female B staying at Peter's address on several occasions. There were a number of significant concerns about both females, separately, financially abusing Peter. This was recognised by practitioners and subject to safeguarding referrals. Peter had told practitioners on occasions, and at different times, that both females were his girlfriend. There was no evidence to contradict Peter's claim so it would have been reasonable to conclude that the financial abuse should have been recognised as domestic abuse committed by an intimate partner. This would then have resulted in a DASH risk assessment being completed. There is no record of domestic abuse being identified by practitioners in Peter's case and therefore, no assessment of the risk of ongoing domestic abuse.

8.8 Exploitation including Financial Abuse

8.8.1 During the period of this review, there were concerns raised by several agencies, including the police, that Peter was potentially being financially exploited by females who were associating with him. Peter made reports direct to the police, on other occasions, the carers contacted the police. When officers questioned Peter, he would deny that Female B or Female A were accessing his money without permission. The police records document that they were informed by partner agencies that Peter had the mental capacity to make decisions about his financial affairs during the period of the review. This perhaps highlights the lack of cohesion and effective joint working between agencies as Peter was assessed by several agencies as not having capacity to make decisions, particularly with respect to financial matters.

8.8.2 Although it would appear that the concerns about financial abuse were not substantiated, this may well have been because Peter was unable to engage effectively with practitioners. It was clear that he suffered from a significant cognitive impairment which limited his ability to weigh or retain information. As has already been discussed in section 8.5 of this report, the Section 42 framework, and its duty to cooperate, may have enabled a more effective response to the risk of financial exploitation that Peter faced. The decision to have a multi-agency meeting to consider the risk of financial abuse was a reasonable response but this was not scheduled until 22 February 2024, almost a year after the concerns were first raised.

8.8.3 As explored in section 8.5 of this report, attendees at the practitioner event determined that the criteria for a Section 42 enquiry would have been met. This may have enabled agencies to work together to develop a plan to safeguard Peter from being financially exploited. Practitioners reminded the review that banks have protocols in place that can respond with additional measures to protect those at risk of financial abuse. Practitioners agreed that where professionals had concerns about vulnerable adults being at risk of financial abuse, it was important that safeguarding referrals were submitted.

8.8.4 There were no concerns identified with respect to George and any potential financial abuse.

8.9 Fire Risk

8.9.1 AF&RS offer a free HFSV for individuals who meet the criteria, this information is shared with partner agencies who can make the referrals direct to AF&RS. George met the criteria and was referred for an HFSV. It took several attempts to complete the visit for George. When the visit was carried out, steps were taken to reduce the risk of fire in George's flat. The referral to AF&RS and the work completed to reduce the risk of fire was seen as good practice. There were, however, further fire-related concerns raised towards the end of 2023 where George was reported as burning holes in the communal carpet with cigarettes. This did not result in a referral to AF&RS or any other fire mitigation action.

8.9.2 In January 2024, the review noted that George was extracted by AF&RS from his flat following a fire which, following investigation, was determined to have resulted from George smoking in bed.

8.9.3 In Peter's case, AF&RS attended a fire at his premises in June 2023, alcohol use was identified as a cause for concern and AF&RS made a referral to Bristol ROADS. This was seen as good practice. It was noted that Bristol ROADS declined to provide any feedback as to the result of the referral. As a result of the referral, they closed the case after two voice mails and two texts were not responded to. This was an issue of concern to the review, and a missed opportunity to mitigate the fire risk for Peter.

8.9.4 AF&RS attended further calls to Peter's property in July, September, and then three calls in November. Although none of these calls were because of an actual fire, it was noted that there was no further referral for an HFSV.

8.10 Impact of the COVID-19 Pandemic

8.10.1 The period subject of this review sits outside of the COVID-19 pandemic 'lockdowns' although there would have been an ongoing impact on some service provision. The main change was to the provision of GP services. The GP practices were asked to move to a triage first model at the beginning of the COVID-19 pandemic. The model relied on telephone, video, and online consultations to support the remote management of patients. This was designed to protect staff and patients from the risk of infection and was in line with national practice.

8.10.2 There was no evidence available to the review to suggest that either George or Peter's access to services was impacted by the COVID-19 pandemic.

8.11 Practitioner Event

8.11.1 The review held a practitioner event in March 2025 which brought practitioners together to consider the identified themes and the context surrounding the decisions and assessments made. It also enabled the review to understand what practice looks like now and brought the practitioner's perspective to the process.

8.11.2 Attendees at the practitioner event considered the themes identified by the review and provided their perspective and additional information to support the process. This has been included in the relevant sections of this report. As well as contributing to identifying learning with this review, the practitioners also recognised elements of good practice and, as some of the attendees had worked directly with either George or Peter, they were able to provide a better understanding of both adults' perspective.

8.11.3 Practitioners were keen to highlight the work of the wardens who provided support to George in his social housing. As well as the support to George and enabling professionals to have a better understanding of George's perspective, the wardens helped professionals engage with George.

8.11.4 The practitioner event reflected on the fact that alcohol related dementia service users may lack any support networks due to having 'burned bridges' with family and friends through long term alcohol use, aggression and possibly violence. This may have isolated them from family and friends over a number of years. It was also noted that there may be a lack of support centres available for such individuals as their behaviour may make them unsuitable for day centre support services.

8.11.5 The practitioner event recognised that the Bristol City Council Anti-Social Behaviour (ASB) team hosted an ASB case conference in August 2023 which considered the risks presented by George at his address. This was a good example of agencies sharing information and assessing risk, supported by legal advice.

9. Conclusions and Recommendations

9.1 Alcohol Dependency

9.1.1 The review recognised that the use of alcohol was a key issue in the lives of both George and Peter, both of whom were identified as dependent drinkers by services. They had both been diagnosed with significant cognitive impairment through alcohol related dementia. Although the review did not have access to their medical records from before 2023, it was clear that they had been using alcohol for a number of years. It was noted that there was a marked difference in how their alcohol use was managed.

9.1.2 George's use of alcohol had clearly been identified by practitioners prior to the period under review. He had been admitted to hospital in late 2022 and when discharged in March 2023, the risk of his excessive alcohol use was recognised by services. It was clear to the review that George had a significant level of support post discharge, and this included support from Supported Independence with respect to alcohol use. When George's increasing use of alcohol became more problematic in the second half of 2023, Supported Independence increased his support to their 'outreach plus' service which included 'seven day a week outreach support' which was seen by the review as good practice.

9.1.3 Peter had been identified as a dependent drinker prior to the period subject to this review. His use of alcohol was assessed by the LLMHT in early 2023, as being the likely cause of his cognitive impairment. Although agencies had regular contact with Peter throughout 2023 and early 2024, and a consistent feature of that contact was his use of alcohol, the steps taken to address this lacked an effective outcome.

9.1.4 During hospital admissions in April and May 2023, the UHBW records document that Peter was referred to the specialist alcohol nursing team which would be seen as good practice. However, there is no documented record of any outcome from either referral.

9.1.5 In June and August, AF&RS made referrals to Bristol ROADS with respect to Peter's alcohol dependence. Making the referrals is clearly good practice, however, DHI attempted to make contact with Peter through two voicemails and, when this was

unsuccessful, through two texts, before closing the referral due to non-engagement. Following the second referral, two appointments were made for Peter, but when he did not attend either appointment, the referral was closed. The review was unsure whether an adult who was a dependent drinker with identified cognitive impairment was likely to respond to phone messages or travel to attend an appointment with services. When the options considered for engaging with Peter are compared to the use of outreach support for George, in two similar cases in terms of service user needs, it is difficult not to conclude that more could have been done to secure Peter's engagement with alcohol use services.

9.1.6 The practitioner event reflected on the challenges of managing dependent drinkers who were diagnosed as having alcohol-related cognitive impairment. The practitioners identified that professionals from some agencies were not sighted on the substance use support services that were available or the referral pathways to access them. Concerns were also raised about the DWS discharging service users back to their GP if they had not been free from significant alcohol use for three months.

9.1.7 DWS explained the importance of dependent drinkers being abstinent from alcohol for three months or, in some cases, using alcohol within the recommended levels before being accepted for assessment (section 8.1 of this report). They accepted that there was a potential gap in service provision although they pointed out that the same potential gap existed for any form of substance misuse that leads to mental, (and possibly physical), morbidity. DWS highlighted to the review that this is a complex area, for example, the Mental Health Act prevents the detention of a person because they are at risk from the mental disorder of addiction.

9.1.8 Practitioners also expressed the view that both Peter and George, as with many dependent drinkers, did not have any supportive networks around them. Long term users of alcohol can have damaged and possibly severed, relationships with family members due to their excessive alcohol use. As such, some of the supportive services offered by the DWS would be a real benefit to them.

9.1.9 The review noted that the police records documented contact with both Peter and George on several occasions. Officers identified that alcohol was a risk factor for both adults and although safeguarding referrals were submitted on occasions, the police did not make any referrals to alcohol support services for either Peter or George. It was recognised that there is no direct referral pathway for substance use available to the police. They would refer substance use concerns through safeguarding referrals to ASC or health agencies. The practitioner event considered that it might not be appropriate for the police to be making direct referrals for support, but that sign posting adults who use substances to available services would be a positive and realistic option.

Recommendation 1

The Safeguarding Adults Board should reassure itself that there is a consistent and effective response to addressing the risk of harm faced by service users with cognitive impairment, who are identified as dependent drinkers.

Recommendation 2

Avon and Somerset Police should promote the signposting of individuals to relevant support services where it is apparent they may be misusing substances including alcohol, alongside completing BRAG assessments and onward referrals where appropriate.

Recommendation 3

Bristol Horizons, who launched the new drug and alcohol services in April 2025, to work with the police to provide training, and to create a pathway, for police colleagues to refer people misusing alcohol for support services.

9.2 Self-neglect

9.2.1 Practitioners identified the risk of self-neglect in both George and Peter's cases although the level of safeguarding referrals submitted was significantly higher in relation to George.

9.2.2 George could not manage his personal hygiene and often declined support from the care staff during the period subject to the review. He was assessed by AWP in September 2023, and it was determined that George lacked insight into his own care needs and lacked the mental capacity to make decisions regarding his health and treatment. Practitioners from several agencies identified the risk of self-neglect and made safeguarding referrals to raise their concerns.

9.2.3 There were only two safeguarding referrals with respect to Peter that specifically referenced self-neglect concerns. The review noted that there was limited recognition of self-neglect in Peter's case despite his difficulties with self-care and alcohol abuse. The lack of consistent safeguarding referrals being submitted may suggest limited awareness or gaps in the protocols for managing patients with self-neglect and associated vulnerabilities.

9.2.4 The practitioner event considered the ability of professionals to identify the risk of self-neglect and the need to make appropriate safeguarding referrals. Attendees suggested that respecting the wishes of the adult and the issue of 'lifestyle choices' may impact on decision making as well as understanding the threshold of when self-neglect becomes a safeguarding matter.

9.2.5 The review recognised that ASC had established a safeguarding advice line which enables practitioners to speak to an experienced social worker and access advice about safeguarding matters. This would include advice on safeguarding in self-neglect cases. The review noted this as good practice although it was clear from the practitioner event that many practitioners were not sighted on this source of support.

Recommendation 4

Bristol City Council Adult Social Care should ensure that practitioners system wide are aware of the safeguarding advice line and how the service can support practitioners with adult safeguarding decision making.

9.3 Mental Capacity

9.3.1 The use of mental capacity assessments in Peter and George's cases was inconsistent.

9.3.2 In George's case, he was assessed in March 2023 whilst in hospital and he was deemed not to have the mental capacity for decisions with respect to his discharge from hospital services. The decision to involve an IMCA to represent his best interests was seen by the review as good practice. When George's mental capacity was assessed in September 2023 by AWP, he was assessed as lacking insight into his care and support needs and lacking the capacity to make decisions relating to his health and treatment. Although at times, practitioners expressed concerns about George's capacity to make decisions, there was limited documented evidence of formal mental capacity assessments being completed.

9.3.3 Both George and Peter were subject to a mental capacity assessment by ASC. The assessment for George did not include consideration of his executive capacity but the social worker did include consideration of executive capacity in the assessment for Peter. In both assessments, the review noted that there was no recorded 'best interest consideration'.

9.3.4 Peter was subject of several mental capacity assessments by SWAST practitioners, primarily relating to being able to decline to be taken to hospital. Some of the assessments determined that he did not have capacity for this decision, and on other occasions, he was deemed to have capacity to decide not to be taken to hospital. The UHBW records did not reflect a consistent use of formal assessments of Peter's mental capacity despite him frequently presenting as confused, intoxicated, and suffering from self-neglect and behavioural changes.

9.3.5 Attendees at the practitioner event informed the review that they were confident that most practitioners had the knowledge and skills to carry out basic mental capacity assessments, but they were less confident that practitioners understood the best interest principles. The review noted that where the adult was deemed to not have capacity to make the relevant decision, there was no documented record of any best interest considerations. It was the view of the practitioner event that this was a learning gap for agencies.

Recommendation 5

The Safeguarding Adults Board should reassure itself that practitioners system wide, understand the need to document their decision making and to record their best interest considerations, where adults have been assessed as not having the mental capacity to make a decision.

9.4 Barriers to Engagement

9.4.1 A number of services had regular contact with both George and Peter but their engagement with services offered was inconsistent. The review recognised the level of support offered to both adults by practitioners and the investment of time to try and engage with them.

9.4.2 The GP recognised that George had a potential learning difficulty and that he was unable to read or write. Arrangements were made to adapt their practice so that George's carers could contact the GP practice on his behalf. This was seen as good practice. The GP practice in Peter's case had difficulties in contacting him throughout the period subject to the review. It was noted that a home visit was used to both engage with him and to better understand his home environment. This was also seen as good practice.

9.4.3 As explored in section 8.1 of this report (alcohol dependency), the review recognised that having identified George as a dependent drinker who was challenging to engage with, Supported Independence invested the time and resource to support and build a relationship with George through their outreach plus capability. Whilst this was seen as good practice, it was very different to the approach taken to try to engage Peter with alcohol support services. The review questioned whether DHI simply offering Peter, an adult with a diagnosis of cognitive impairment and lacking capacity, appointments by phone messages was an effective engagement option. On the second occasion, when Peter did not attend two appointments, the referral was again closed. There was no documented engagement with other agencies to try and secure Peter's engagement with the service. Attendees at the practitioner event suggested that services may need to fit the needs of the service user, rather than the service user meeting the needs of the service.

9.4.4 The practitioner event considered the challenges of building a meaningful relationship with a service user when a number of professionals are involved in a case, particularly when the adult had complex needs. It was also noted that some agencies had 'episodic' contact with both George and Peter with little or no opportunity for relationship building. Attendees suggested that an advocate could have been used to try and improve the limited engagement with both adults. This would have enabled communication to be channelled through one contact point which may have enabled the adult to engage more effectively with the services offered. The review recognised that the MASH was reported to be actively encouraging referrals for the use of advocates in relevant safeguarding scenarios. This was seen as good practice and negated the need for the review to make a recommendation with respect to this issue.

Recommendation 6.

The Safeguarding Adults Board should seek reassurance from Bristol Horizons that their non-engagement policy meets the needs of service users who may have complex needs and who may have difficulty engaging with services.

9.5 Use of Section 42 Framework

9.5.1 The review recognised that there were many examples of good information sharing between agencies with respect to both George and Peter, including the submission of several safeguarding referrals. It was however noted that there was no single agency who appeared to have a holistic understanding of the risks that either of the two adults subject of this review faced. As a result, agencies sought to tackle issues in silos with no co-ordinated cross agency plan to mitigate the risk and no single agency was identified as having clear ownership of leading that cross-agency response.

9.5.2 Although most agencies recognised the risk from alcohol use, agencies had a limited understanding of the wider risks that either adult faced. Some agencies identified that neither Peter or George had capacity with respect to decision making about their care and support, and other agencies appear to have assumed that they did have capacity to make such decisions. A more joined-up approach may have enabled George and Peter's care and support needs to be better met.

9.5.3 Whilst the review recognised that there was some evidence of multi-disciplinary meetings in the case of both adults, and there was a multi-agency meeting in October 2023 in respect of Peter, there was no documented consideration of using the Section 42 framework under the Care Act 2014. This would have brought the relevant agencies together with a duty to cooperate and enabled a joint, co-ordinated response to the risk in George and Peter's cases.

9.5.4 The review considered each of the elements of the requirement for a Section 42 enquiry in line with the Care Act 2014 and determined that it would be reasonable to conclude that the threshold for a Section 42 enquiry was met. This view was tested at the practitioner event who agreed that the threshold for Section 42 was met with respect to both Peter and George. In reaching this conclusion, practitioners recognised that both Peter and George were in receipt of care and support packages. Decision makers in Peter and George's cases may have seen that as an alternative to safeguarding rather than being part of the safeguarding process.

9.5.5 The fact that the formal Section 42 framework was not used was a missed opportunity to bring agencies together under the statutory duty to cooperate, to develop a holistic view of the risk that both George and Peter faced, and to agree a cross-agency plan to mitigate that risk. This may have enabled their care and support needs to be better met.

9.5.6 The review noted that the MASH is a multi-agency structure with several safeguarding agencies participating. This is seen as good practice and enables safeguarding referrals to be considered holistically with more effective information sharing.

Recommendation 7

Bristol City Council Adult Social Care should ensure that relevant practitioners understand how to apply the Section 42 criteria in cases involving self-neglect,

substance use or the risk of exploitation. This would include adults at risk of one of these issues, or those like Peter, where all three risks may apply.

9.6 Deteriorating Health Conditions including Mental Health

9.6.1 George and Peter had significant physical health needs and had regular contact with health services. In both cases, their cognitive impairment and ongoing alcohol abuse had a negative impact on the ability of health professionals to treat their health needs.

9.6.2 George had several physical health concerns, and the GP found engaging with him to address these needs challenging. It was also difficult to ensure that he took his medication in an appropriate manner. The GP had engaged with George's support worker to aide compliance. The GP had also carefully documented medication reviews and medication discussions with other professionals who were involved in George's care and support. This was seen as good practice.

9.6.3 In Peter's case, he had several health issues as well as his deteriorating cognition and alcohol use. His medical records suggest that he could not be prescribed the normal medication for some of these conditions because of the risk of falls, haemorrhage, and persistent alcohol intoxication.

9.6.4 There were no recommendations made with respect to George and Peter's deteriorating health conditions.

9.7 Domestic Abuse

9.7.1 There was no evidence available to the review to suggest that George was either a victim or perpetrator of domestic abuse. Peter informed practitioners on occasions that both of two females were his girlfriend. When concerns were raised about financial exploitation, the abuse could have been considered to be domestic abuse which would have required a DASH risk assessment to be completed. The review noted that professionals may have considered that it was highly unlikely that there was any intimate relationship between Peter and either of the two females in this case. This was recognised as reasonable decision-making based on the available information. There were no recommendations with respect to domestic abuse.

9.8 Exploitation including Financial Abuse

9.8.1 Concerns were raised by several agencies that Peter may have been financially exploited by females who were associating with him. Whilst Peter would occasionally make allegations about financial abuse, when questioned by police, he would deny that either of the two females were accessing his money without his permission. The police records document that they were informed by partner agencies that Peter had the mental capacity to make decisions about his financial affairs during the period of the review. This reflects the lack of co-ordination between agencies as health and social care practitioners had determined that Peter did not have capacity to make decisions, particularly with respect to financial matters.

9.8.2 Whilst the concerns about financial abuse have not been substantiated, it may be because Peter was unable to engage effectively with services. As previously discussed within this report, use of the Section 42 framework, and its duty to cooperate, may have enabled a more effective response to the risk of financial exploitation that Peter faced. This was supported by attendees at the practitioner event who agreed that the use of the Section 42 framework may have enabled professionals to work together to develop a plan to safeguard Peter from the potential risk from financial exploitation.

9.8.3 The review has already made a recommendation with respect to the use of the Section 42 framework. There was no requirement to make a further recommendation specific to financial abuse.

9.9 Fire Risk

9.9.1 Both Peter and George had contact with AF&RS during the period subject to the review. In Peter's case, AF&RS attended a fire at his home and having identified that alcohol use was a factor for future fire risk, made a referral to Bristol ROADS. Although the referral did not result in any effective engagement with Peter, Bristol ROADS declined to provide feedback to AF&RS. The fire risk was not mitigated, and this was a concern to the review and noted as a missed opportunity to better safeguard Peter. It was also noted that although AF&RS attended three further calls to Peter's home in the second half of 2023, there was not a referral made for an HFSV.

9.9.2 AF&RS completed an HFSV at George's premises following a referral from ASC. As part of the visit, appropriate steps were taken to reduce the risk of fire within George's flat. This was seen as good practice. Later, in December 2023, further fire-related concerns were raised as George was reported to be burning holes in the communal carpet with cigarettes. The review noted that the risk identified did not result in a referral to AF&RS or any other fire mitigation action. In January 2024, George was extracted by AF&RS from his flat following a fire which, following investigation, was determined to have resulted from George smoking in bed. The failure to make a fire safety referral after the reported fire safety concerns in December 2023 was a missed opportunity to mitigate the identified risk of fire in George's case.

Recommendation 8

The Safeguarding Adult Board should ensure that relevant practitioners recognise the importance of making fire safety referrals where a fire risk is identified and the case involves adults who are cognitively impaired or who are recognised as being dependent drinkers.

Recommendation 9

Bristol Horizons should provide assurance to the Safeguarding Adults Board that they have the appropriate policy in place to ensure that where a referral to their

service is closed without engagement with the service user, feedback is provided to the referring agency to enable risks to the service user to be appropriately managed.

10. Appendix 1. Table of Recommendations

No.	Recommendation.	Theme.	Agency.
1	The Safeguarding Adults Board should reassure itself that there is a consistent and effective response to addressing the risk of harm faced by service users with cognitive impairment, who are identified as dependent drinkers.	Alcohol Dependency	Safeguarding Adults Board.
2	Avon and Somerset Police should promote the signposting of individuals to relevant support services where it is apparent they may be misusing substances including alcohol, alongside completing BRAG assessments and onward referrals where appropriate.	Alcohol Dependency	Avon and Somerset Police.
3	Bristol Horizons, who launched the new drug and alcohol services in April 2025, to work with the police to provide training, and to create a pathway, for police colleagues to refer people misusing alcohol for support services.	Alcohol Dependency	Bristol Horizons.
4	Bristol City Council Adult Social Care should ensure that practitioners system wide are aware of the safeguarding advice line and how the service can support practitioners with adult safeguarding decision making.	Self-neglect	Bristol City Council Adult Social Care.
5	The Safeguarding Adults Board should reassure itself that practitioners system wide, understand the need to document their decision making and to record their best interest considerations, where adults have been assessed as not having the mental capacity to make a decision.	Mental capacity	Safeguarding Adults Board.
6	The Safeguarding Adults Board should seek reassurance from Bristol Horizons that their non-engagement policy meets the needs of service users who may have complex needs and who may have difficulty engaging with services.	Barriers to engagement	Safeguarding Adults Board.
7	Bristol City Council Adult Social Care should ensure that relevant practitioners understand how to apply the Section 42 criteria in cases involving self-neglect, substance use or the risk of exploitation. This would include adults at risk	Use of section 42 framework	Bristol City Council Adult Social Care.

	of one of these issues or, those like Peter, where all three risks may apply.		
8	The Safeguarding Adult Board should ensure that practitioners system wide recognise the importance of making fire safety referrals where a fire risk is identified and the case involves adults who are cognitively impaired or who are recognised as being dependent drinkers.	Fire risk	Safeguarding Adults Board.
9	Bristol Horizons should provide assurance to the Safeguarding Adults Board that they have the appropriate policy in place to ensure that where a referral to their service is closed without engagement with the service user, feedback is provided to the referring agency to enable risks to the service user to be appropriately managed.	Fire risk	Bristol Horizons.

11. Appendix 2. Table of single agency recommendations

11.1 A number of agencies had identified potential single agency recommendations whilst preparing their IMRs. These recommendations are not necessarily evidenced within the report but will be actioned internally by the agency concerned. They are listed within appendix 2 for the information of the KBSP Board.

No.	Recommendation.	Agency.	Intended outcome
1	Improve inter-agency communication between AF&RS and BCC ASC.	Bristol City Council Adult Social Care	To develop better routes of communication between AF&RS and ASC.
2	Develop and promote a BCC ASC internal self-neglect protocol.	Bristol City Council Adult Social Care	To provide a safer response for service users living with self-neglect that ensures the application of appropriate legal frameworks.
3	To work with Bristol MARAC to provide training in delivering MARAC referrals for relevant ASC practitioners.	Bristol City Council Adult Social Care	To develop a greater understanding of the MARAC process across ASC teams.
4	Ensure that safeguarding referrals include detailed information of all of the concerns for an adult at risk.	SWAST	To improve the quality of safeguarding referrals submitted to partner agencies.
5	To provide and develop specialist training for senior operational staff to support with decisions in relation to complex mental capacity assessments and to include case study based scenarios.	SWAST	To improve the quality of documentation relating to Mental Capacity Act assessments and onward referrals.

6	Record health information promptly on to the CX system.	LiveWest.	Improved recording of information to support decision making.
7	Provide relevant practitioners with additional training re indicators of domestic abuse.	LiveWest	Improve the ability of frontline practitioners to identify indicators of domestic abuse.
8	Provide additional guidance to practitioners with respect to making safeguarding referrals.	LiveWest	Increased safeguarding awareness.
9	Ensure that damage to communal doors is identified and repaired promptly.	LiveWest	Improved security for service users.
10	The Lighthouse Safeguarding Unit to ensure that practitioners are able to recognise when care and support needs may exist for adults suffering from brain disorders and mental ill-health and make onward referrals to ASC.	Avon and Somerset Police	To ensure that risks are identified and appropriate referrals are made to ASC.
11	Refresh and re-promote the home fire safety visits (HFSV) guidance from Avon & Fire Rescue Service (AF&RS) to the STOP team.	Bristol City Council Housing and Landlord Services	Referrals are made to AF&RS when fire risk behaviour identified to reduce risk of harm to the tenant and the community.
12	To work with STOP to develop a process for providing advice/guidance to tenants to report safeguarding concerns in relation to neighbours to the ASC website or via the telephone.	Bristol City Council Housing and Landlord Services	All concerns for an individual at risk are reported to ASC.
13	Review process for promoting HFSV referral mechanisms to external agencies.	AF&RS	To increase HFSV referrals from key agencies who support individuals who present with higher fire risk behaviours.
14	Improve practitioners use of professional curiosity.	AF&RS	Improve the use of professional curiosity by practitioners to identify risk to service users.
15	ICB to complete the DNA/WNB policy guidance and share it as a resource for GP practices.	ICB Primary Care Team	Increased knowledge and confidence in responding to non-attendance.
16	ICB to promote the use of timely mental capacity assessments across Primary Care.	ICB Primary Care Team	Improve knowledge of timely mental capacity assessments across Primary Care.
17	ICB to promote the use of internal safeguarding meetings within Primary Care to support the management of risk in complex cases.	ICB Primary Care Team	To increase the use of internal safeguarding meetings to escalate concerns and to better mitigate risk.
18	Establish and implement a rapid safeguarding referral protocol for A&E.	UHBW	To increase the number and consistency of safeguarding

			referrals made by A&E practitioners.
19	To improve the identification and assessment of patients' mental capacity when signs of cognitive impairment, substance misuse or confusion are present.	UHBW	Improved completion and accuracy of mental capacity assessments in high-risk cases.
20	To explore methods to improve the comprehensive and accurate documentation of safeguarding concerns in A&E within the current digital platform to support continuity of care and follow up by other departments.	UHBW	Improved documentation for safeguarding concerns in A&E will improve practice and ensure that there is consistency in identifying increasing safeguarding risks in patients.
21	Review current domestic abuse training to ensure that it includes the abuse of older victims, male victims and wider forms of exploitation.	UHBW	To improve the identification of domestic abuse and the mitigation of the risks that service users face.
22	Strengthen A&E leadership in safeguarding and supervision.	UHBW	Increased staff confidence and knowledge of safeguarding measured through feedback surveys and supervision sessions.
23	Safeguarding training to be rolled out across access services.	AWP	Ensuring practitioners are able to identify and respond effectively to indicators of abuse and safeguarding concerns.

12. Appendix 3. Narrative Chronology – George

12.1 Prior to 2023, it was noted that there had been a significant number of contacts with the AF&RS since late 2019 with concerns relating to the potential fire risk through George's dementia and being a heavy smoker.

January 2023 to December 2023

12.2 George had been admitted to UHBW in December 2022.

12.3 Sirona records for January documented their use of the transfer of care document to evidence the need for a pathway 3 dementia bed for George as part of the discharge planning process. There was liaison with George's social worker recorded and following a mental capacity assessment, George was referred for an IMCA.

12.4 The Sirona records document that the IMCA challenged the pathway 3 decision. A multi-disciplinary team meeting (MDT) was held to discuss George's case, albeit Sirona were not invited, and it was determined that it would be in George's best interests to have a pathway 3 bed allocated to him.

12.5 The Sirona records throughout February document significant liaison between agencies with continued support for a pathway 3 bed allocation. It was noted that there were challenges securing a placement.

12.6 On 24 February, Sirona records document a request to review the pathway 3 bed decision as George would like to go home and his IMCA was supporting this. The proposal from an MDT meeting was that George's needs could be met at home with a four times a day Sirona reablement support package. It was noted that George did not have the capacity to make a decision regarding his discharge planning. It was also acknowledged that George may start drinking alcohol again on discharge.

12.7 In early March, it had been agreed that George would be subject of pathway 1[13] support to live at home. It was further noted that George was not considered to have capacity to make the decision to go home and be supported to live there. Within that assessment, it was recognised that he may start drinking again but it was seen as the least restrictive option. It was also noted that George had previously refused to engage with the Sirona reablement service. Sirona would expect George to sign a contract about not drinking alcohol prior to or during their visits, he also wouldn't be permitted to smoke. A breach of this contract could see the service being withdrawn from him. This information was shared with relevant partner agencies.

12.8 On 12 March, the concerns about George being discharged to his home address and the ability of Sirona to provide adequate care to meet his needs were raised to the Sirona lead for their community transfer of care hub. Despite the discussion between teams and the concerns raised, in particular, by Sirona, George was discharged to his home address on 22 March 2023. Sirona were informed that a four times a day care package of support had been agreed for George and that Sirona reablement team would not need to be involved. A discharge letter was shared with the GP practice.

12.9 On 22 March, the community therapy team visited George to complete a P1 post discharge assessment. No therapy needs were identified, and George was discharged from the service.

12.10 On 23 March, the Bristol City Council Housing and Landlord Services (BCC HLS) records documented that George had returned to his home address yesterday. He was confused and angry as he wanted alcohol. He was quite threatening in his behaviour towards the visiting practitioner who also noted that George was throwing cigarette ends on the floor without understanding the risk of fire. They also reported that George has five carer visits per day, but they could only do welfare checks as George was refusing any support from them.

12.11 On 24 March, the same BCC HLS practitioner attended George's address and found him wandering around the building stating he was lost. She escorted him back to his flat.

12.12 On 27 March, the police received information from the care providers that George had threatened to stab himself to death. SWAST had been called but would only

[13] Level of support agreed to enable George to live at home on discharge from hospital.

attend if accompanied by the police. SWAST records document that George had low level confusion but was not having suicidal thoughts. He was deemed fit to be left in the flat. A safeguarding referral was submitted with respect to George's self-neglecting behaviour.

12.13 On the same day, the GP practice record the concerns shared with them by the care providers about George's mental health, including low mood, suicidal thoughts, and the fact that George was not taking his medication or eating. The entry on George's medical records was not flagged as a safeguarding concern. On the following day, the GP practice documented that concerns shared by SWAST, and a mental health worker were in keeping with chronic rather than acute behaviours. They were also unable to contact the care providers. George was not contacted.

12.14 On the same day, BCC HLS staff visited George, they found him semi dressed and very cold. It was clear that he had not been taking his medication but did so when prompted. The BCC HLS staff also bought George a cup of coffee and a sandwich.

12.15 On 30 March, the GP practice documented a discussion with the mental health worker. George's deteriorating mental health and his not taking medication were considered. It was also noted that he was not accepting support or allowing a mental health worker into his flat. A referral was submitted to the mental health team for an assessment.

12.16 On 6 April, the GP practice paramedic carried out a home visit. The issue of not taking medication was recorded. The paramedic recorded that George appeared to have capacity for simple decisions, but the practitioner would 'question George's ability to retain and weigh up…' The paramedic also noted the strong smell of cigarette use. Concerns about self-neglect were recorded.

12.17 On 11 April, the GP practice had contact with both the social worker and George's support worker considering a DWS referral now that George had, in their words, stopped drinking. There is an entry on George's medical record for the following day, that the DWS will not intervene as George is drinking alcohol again. The record also documents that the social worker planned to arrange a professionals meeting.

12.18 The AWP record provided to the review documented that the DWS recorded that this was a complex triage. The GP needed to consider a possible Mental Health Act assessment and a referral to the Community Mental Health Team (CMHT).

12.19 The GP record on the 21 April documented that the DWS declined to accept the referral because George was drinking 28 units of alcohol a week. The GP practice documented that this is not correct and that George has not drunk alcohol since his discharge from hospital in March.

12.20 Later the same day, the practice mental health practitioner (MHP) carried out a home visit to George. The MHP documented that George was able to answer questions albeit in a delayed style. They discussed routine health matters; George would not talk about his medication and the MHP identified the risk of self-neglect. The MHP shared information about the visit with ASC and sought to arrange a joint visit.

12.21 On 10 May, the police received a call from George's support worker stating that George had left his flat and was walking down the middle of the road. By the time police arrived, the support worker had returned George to his flat and no further action was taken.

12.22 On 28 June, neighbours reported to the police that George was self-harming and making threats to harm others. Officers spoke to George; he would not let them check him for injuries but said that he did not wish to live in his flat any further. He also expressed suicidal ideation. He refused any offer of mental health support or any other support.

12.23 On 2 July, George reported that he had been a victim of a burglary. The carers expressed doubt that a burglary had occurred, and the police were unable to find any evidence of a crime.

12.24 On 10 July, ASC received a safeguarding referral with respect to George from a housing officer raising concerns about self-neglect. The concern specifically highlighted the fire risk. A safeguarding enquiry was opened. A referral was made to AF&RS.

12.25 On 17 July, AF&RS received a referral for a HFSV for George from ASC. The concerns being related to smoking, alcohol use, poor memory and cognition, and his mobility difficulties.

12.26 The allocated social worker left ASC on 21 July, and the case was placed on the waiting list for reallocation as a high priority case due to outstanding actions.

12.27 On 5 August, police were called to concerns about George walking in the road in a confused and drunken state. Officers spoke to George who was aggressive and threatening. He was initially arrested for a public order offence but after the arresting officers liaised with the mental health triage team, George was taken home and no further action was taken.

12.28 During early August, the warden dealt with issues relating to George on two occasions. A further safeguarding referral, submitted by the housing officer, was received by ASC on 11 August. This referral raised a concern about the alleged neglect by the care agency in not supporting emergency call outs the day before. There were also concerns about self-neglect.

12.29 On 15 August, a new social worker was allocated to George's case.

12.30 On 16 August, ASC received a safeguarding referral from George's warden relating to self-neglect and the level of emergency call outs to manage George and his behaviour.

12.31 On 18 August, the warden was called to George's flat as he was laying on the floor of the bathroom, drunk, and in a pool of urine. George was verbally aggressive towards the warden. The warden reported concerns to the police about George being drunk and making threats. They did not want to support formal police action. The community warden stated that George was very unwell and that his

accommodation was not appropriate. The police were informed that a meeting was scheduled to consider George's accommodation issues.

12.32 On 23 August, a social worker and a support worker from Supported Independence, visited George at home. It was agreed that an MDT would be held in early September and a follow up visit was arranged for 31 August.

12.33 On 25 August, Careline raised concerns with the police regarding George's welfare. Officers attended George's address and spoke to George who was in a drunken and confused state. They spoke to the warden who said that they would escalate their concerns.

12.34 On 31 August, the social worker and a support worker, carried out a follow up visit to George's flat.

12.35 George was referred back to AWP in September by the GP practice who were concerned about his self-neglect, alcohol intake and his lack of capacity.

12.36 In September, the AWP records documented that the Bristol Mental Health Service Single Point of Access (SPA) team received a referral with respect of George. The record documented an assessment which concluded that there was no evidence of acute clinical depression or acute psychosis. George was described as experiencing a progressive decline in his cognitive function. He was assessed as presenting as a high risk of falls and lacking insight into his care needs. The assessment also stated that George lacked capacity to make decisions regarding his health and treatment. They added that he could not appreciate the risks he posed to himself without an appropriate care package being in place. He was discharged to the social worker to review his care package.

12.37 On 7 September, the social worker escalated George's case to a supervisor and agreed to seek alternative accommodation options for George.

12.38 On 12 September, George's case was discussed at the Support Options Forum meeting and several actions were agreed.

12.39 On 13 September, George's case was discussed at a safeguarding MDT. Several actions were agreed. A follow up meeting was agreed for 12 October.

12.40 On 12 October, a follow up safeguarding review meeting was held and actions agreed. Four days later, a care act assessment was authorised.

12.41 On 16 October, George was seen by a psychiatrist from AWP. George was determined to not have acute mental ill health. His Olanzapine medication was stopped as he was not taking it, and it increased his risk of falls when taken with alcohol. The psychiatrist discharged George back to the GP as it was felt that there was no longer a role for the recovery team.

12.42 Later the same day, George was taken to UHBW after being found wandering in the street. He was assessed as being at his base line presentation and discharged.

12.43 The GP records documented that during October, George was offered support with respect to his alcohol use. He declined any referral as he said he enjoyed drinking. He was also referred to community therapy in relation to his mobility issues.

12.44 On 17 October, the police were called to George's address by Careline with respect to concerns about people in his flat. On attendance, officers reported that George was suffering from documented alcohol related dementia. A referral was made to the Lighthouse safeguarding team[14]. As officers were aware that George was under the care of 'appropriate health care professionals', no further safeguarding referrals were made.

12.45 On 19 October, funding was agreed for additional weekend support from Supported Independence to help George manage his use of alcohol. This would commence on 21 October.

12.46 The HFSV by AF&RS was finally completed on 26 October, a visit was unsuccessful on 5 September and was further cancelled twice in early October. Fire retardant spray was used on George's bed and where burn marks were identified in the flat. The South Bristol Intermediate Care staff were unable to attend the visit. The AF&RS liaised with the warden. There was no suggestion of a follow up visit.

12.47 On 7 November, Supported Independence began providing 'outreach plus' support for George.

12.48 On 14 November, the community therapy team completed a falls assessment with George. He had been on the waiting list since August. George declined any walking aids or further assessment. He was discharged from the service.

12.49 On 29 November, George attended a telephone appointment with the Sirona bladder and bowel service, assisted by Supported Independence. A face-to-face meeting was planned for 15 January 2024.

12.50 On 8 December, the housing officer contacted the social worker by email to report concerns about George urinating in communal areas outside his flat and burning a hole in the communal carpet with a cigarette. The social worker replied, asking for more details of the incidents. The social worker also raised the incidents with Supported Independence to see if they were aware of the issues.

12.51 On 9 December, George contacted the police to report two males damaging his fence and attempted to gain entry to his flat. Officers attended the address. There was no damage to the fence and George confirmed that no-one had tried to enter his flat.

12.52 On 27 December, a mental health support worker contacted the community therapy team to request a joint visit with an occupational therapist to see George. This was booked for 17 January 2024.

January 2024

[14] The Lighthouse safeguarding team offer enhanced services to vulnerable, intimidated or persistently targeted victims of crime and anti-social behaviour.

12.53 On 10 January, Supported Independence informed the social worker that George was deteriorating further. The concerns included increased confusion; an example given was that George didn't know how to get out of the lift. The social worker asked Supported Independence to contact George's GP.

12.54 On 11 January, shortly before 8am, AF&RS attended an emergency call to a fire at George's flat. George was rescued from the flat in an unconscious state. The fire investigation believed that the cause of the fire was through smoking in bed.

12.55 On a date in mid-January, George died in hospital.

13. Appendix 4. Narrative Chronology - Peter

January 2023 to December 2023

13.1 On 4 January, the GP practice received information from the LLMHT relating to an assessment of Peter in December 2022. On MoCA[15], he had scored poorly on memory and verbal tasks. Clinically, the letter stated that the evidence of cognitive impairment probably had a mixed origin. Alcohol was assessed as a likely major causative factor with previous falls and subdural haematoma also likely to have contributed. The record stated that the radiological changes are of a severe global atrophy[16] and frontal gliosis[17]. Whilst a further review had been planned, Peter was discharged with his 'usual care package' before this could take place. The GP practice sent a text message to Peter on the same day, inviting him to book an appointment to arrange a referral regarding his diagnosed memory issues.

13.2 On 19 January, LiveWest received a report from a neighbour that Peter had not had running water at his premises for three weeks. It had been turned off by another neighbour due to a leaking tap but carers, who visit the premises four times a day, had reported the issue at the time. The neighbour also reported that the carers did not always attend four times a day.

13.3 On 24 January, LiveWest received a report that Peter had bed bugs. The support worker had made Peter aware that this was not a repair issue and was his responsibility.

13.4 On 30 January, Peter was found by police in the street with a head injury. He refused any treatment and was taken home by the police staff. Whilst with the police, Peter received a telephone call from his son, he was complaining about the Protection from Harassment Order.

13.5 Later the same day, Peter contacted the police to report a male at his address who was refusing to leave. On police arrival, there was no-one else at the property, Peter

[15] Montreal Cognitive Assessment---A simple, in office test for mild cognitive impairment and early onset dementia.
[16] Global atrophy---a condition that causes a reduction in the brain volume that affects almost all of the brain's lobes. It can be as a result of aging but also diseases such as Alzheimer's' disease.
[17] Gliosis---a non-specific reactive change of glial cells in response to damage to the central nervous system.

was very confused. The police were concerned about the unsuitability of the accommodation for Peter and submitted a safeguarding referral to ASC the following day.

13.6 On 25 February, police received a telephone call from Peter asking to have someone removed from his premises. Peter could not remember his address. Peter's carer then spoke to police, advising that Peter's friend Female A was at the address and that Peter was drunk. They advised that the police were not required.

13.7 SWAST attended Peter's address on 26 February, following a 999-call, concerning a head injury. The SWAST records document that Peter had suffered a fall the previous day which had increased his confusion. He had then fallen again that day. The records document that Peter was a dependent drinker. Peter was taken to ED (UHBW) where he was admitted with a suspected fractured skull. Peter remained in hospital until discharged on 2 March. Whilst Peter was in hospital, the staff submitted a safeguarding referral following guidance from their safeguarding team, as an intoxicated person had tried to visit Peter and Peter had tried to leave the ward to get money. Staff were conscious that there had previously been concerns about financial abuse. It was also documented that referrals were made to the falls and frailty team and to the dementia, delirium and falls team who were seeking support for Peter. Information was also passed to the GP practice by SWAST, notifying them of Peter's intoxication, accidental fall and head injury.

13.8 On 13 March, police were called to Peter's address by his carers reporting that a female sex worker had attended Peter's address and told his friend Female A to leave. The police and carers were concerned about possible financial exploitation. The police records document that Peter had a social worker, care-coordinator, a carer and was considered to have capacity. Peter was subsequently interviewed by police in the presence of a carer but couldn't remember any details of the incident, so the investigation was closed.

13.9 On the same day, SWAST were called to Peter's address by Female A as Peter was unresponsive. On arrival, Peter was found to be asleep having been drinking cider. SWAST shared information with the GP practice.

13.10 During March, the GP practice tried to contact Peter to discuss his medication, but Peter did not respond.

13.11 On 27 March, Police were contacted by Peter's carer who reported concerns about Female A and another female exploiting Peter financially. There were also concerns about Peter's mental capacity. The police made a referral to ASC which noted that Peter was unable to protect himself from the risk of abuse/exploitation.

13.12 On 2 April, SWAST attend a 999-call to Peter's address. No acute problems identified but SWAST practitioners raised a safeguarding concern about cuckooing and financial exploitation. It was also noted that the carer, who provided four times a day care input, had concerns about Peter's earlier intoxication. The GP records documented information sharing from SWAST.

13.13 Later the same day, an ASC visit was recorded, and they were told to leave by Peter and Female A. Police attended, Peter was happy with Female A's presence, stating she cooks, cares and cleans for him. The house was tidy and there was food in the fridge.

13.14 On 7 April, SWAST attend Peter's address following a 999-call. The care-coordinator was also in attendance. During the assessment, a female attended the address claiming to be a friend of Peter's and asked to be recorded as the next of kin (NOK). She was identified as a known sex worker by the SWAST crew who declined to record her as the NOK. A mental capacity assessment was recorded by SWAST with respect to the decision as to whether to go to hospital, and Peter was determined as lacking capacity. He was conveyed to the ED (UHBW). A safeguarding referral was raised and provided to hospital staff. SWAST also shared information with the GP practice.

13.15 UHBW records documented that Peter was referred to the alcohol specialist nurse with regard to his alcohol dependency, worsening unsteadiness, and confusion. The safeguarding team were consulted and a safeguarding referral submitted. Peter was discharged on 12 April. A discharge letter was provided to the GP practice, this referred to Peter's chronic continuous alcoholism and falls.

13.16 In late April, as well as attempting to contact Peter, the GP practice updated Peter's medical records with the fact that Peter was not responding to GP contact and flagged the record as a safeguarding concern.

13.17 On 2 May, Peter presented to ED (UHBW) with an injury to his hip and knee. He was diagnosed as having a possible strain injury, but the records do not evidence any referrals or how the injury occurred.

13.18 On 4 May, the police were called twice, once by Peter at 0300, and then again later that morning by a carer. Peter had reported that two men had removed his cooker. On police attendance, Peter could not remember the incident. The police record documented a referral to the Neighbourhood Policing Team (NPT) in relation to concerns about cuckooing. A safeguarding referral was submitted to ASC.

13.19 On the same day, the GP practice documented attempts by the care co-ordinator to contact Peter and then a referral to Sirona for a multi-factorial falls risk assessment. It was noted that Peter was admitted to hospital, (14 May), prior to Sirona arranging a home visit.

13.20 On 12 May, the police attended Peter's address following a call from Peter reporting that a male and female was at his address dressed as clowns. A BRAG[18] assessment noted a concern that Peter's dementia was getting worse. The police also attended Peter's address twice on the next day following similar allegations. Two safeguarding referrals were submitted to ASC by attending officers.

[18] BRAG is an assessment tool used to assess vulnerability and safeguarding. A person would be considered vulnerable if they are unable to protect themselves or others from harm or exploitation.

13.21 On 14 May, SWAST attended a 999-call at Peter's address. Peter was conveyed to ED (UHBW) due to concerns about vulnerability and new onset delirium. The SWAST crew raised a safeguarding concern which was handed to hospital staff. The UHBW records documented Peter's confusion and that this may have resulted from a fall. He was admitted, remaining in hospital until his discharge on 19 May. It was noted that UHBW staff had referred Peter to the specialist alcohol nursing team and that they had submitted a safeguarding referral. The safeguarding referral highlighted concerns about exploitation, financial abuse and his alcohol usage. SWAST and UHBW both provided information to the GP practice.

13.22 Police records highlight that Peter was reported missing from the hospital having been taken for a walk by his son on 18 May. It was noted that the UHBW staff were aware that his son was not allowed access to his father but permitted him to take his father for a walk. Peter was located at his home address and returned to the hospital. Peter's son was arrested for breaching a Protection from Harassment Order that he was subject of (a subsequent Crown Prosecution Service review resulted in no further action being taken). A BRAG assessment contained concerns about exploitation and that Peter had informed officers that Female A was his girlfriend.

13.23 The GP spoke to Peter by telephone on 23 May and informed him of arrangements for the planned meeting on 26 May. The GP record documented concerns about Peter's memory and his mental capacity for some decision making.

13.24 On 26 May, the GP practice recorded a planned face-to-face appointment with Peter and the GP with the care coordinator also being present. The focus was on Peter's memory and the fact that this was made worse through alcohol use.

13.25 On 10 June, the police attended Peter's address following Peter reporting that males were present who would not leave. The police could get no answer at the door. The next day, 11 June, the police received a similar call and this time, they were able to speak to Peter. There was no one else present. Peter appeared confused and he was unsteady on his feet. There was no referral to ASC as there was already a care package in place.

13.26 In the afternoon of 11 June, the AF&RS attended a call to a fire alarm and the smell of burning at Peter's address. Peter was found asleep in the living room. He was conveyed to ED (UHBW) by a SWAST crew. Peter was unharmed, he had been intoxicated and the food he had been cooking had caught fire after he fell asleep. UHBW records document that Peter was referred to the specialist alcohol nursing team. There was mention that an IMCA was considered but no actual record as to whether a mental capacity assessment was completed. There was also no record of a safeguarding referral being made.

13.27 The Sirona records document their involvement in the discharge planning for Peter. The Sirona practitioner noted the concerns raised on the transfer of care document. Sirona recommended a pathway 3 social care assessment bed. This recommendation was sent to the integrated discharge service team at UHBW. Peter was discharged to his home with a care package of support agreed, Sirona closed their referral. A copy of the discharge summary was sent to the GP practice.

13.28 The following day, AF&RS raised an internal alert due to the concerns about a fire risk. This led to a request for a HFSV. They also made a referral to Bristol ROADS[19]. The HFSV didn't take place as AF&RS were unable to contact Peter. It was noted that SWAST also made a referral to AF&RS requesting a HFSV, this was closed as the AF&RS initiated request for a HFSV was still open.

13.29 It was also noted that SWAST shared information relating to this incident with the GP practice. The GP practice made a referral to ASC regarding self-neglect.

13.30 On 11 July, AF&RS attended a false fire alarm at Peter's address. Although there was no fire, it was documented by AF&RS, that Peter could not have responded as he was intoxicated. LiveWest records document that they attended Peter's address on 13 July to replace the fire alarm.

13.31 On 17 July, SWAST attended a 999-call to Peter's address. A carer reported that Peter was drunk, had injured his arm and couldn't get up. There were concerns about a possible head injury from a fall. The SWAST crew documented a mental capacity assessment which determined that Peter did not have capacity to make a decision about going to hospital for treatment. Peter was taken to the ED (UHBW). He was assessed as having no obvious injuries, a chronic alcoholic, confused and at risk of malnutrition. He was admitted for observation and discharged on 24 July. A safeguarding referral was made to ASC, as UHBW had concerns about Peter's living conditions and his ability to keep himself safe. A discharge letter was sent to the GP practice raising the same concerns.

13.32 On 9 August, the GP practice noted the concerns regarding Peter's safety at home within the recent discharge summary. They documented that as Peter had been allowed to self-discharge from hospital on a number of occasions, he must be considered to have decision making capacity. It also noted that the frequent falls were linked to alcoholism.

13.33 During August, several attempts were made by DHI to contact Peter to arrange a meeting to consider support with respect of his dependent drinking. After two left voicemails and two text messages, the referral was closed on 14 August.

13.34 On 31 August, following a further Bristol ROADS referral from AF&RS, DHI contacted Peter and arranged an assessment appointment for 7 September.

13.35 On 4 September, AF&RS attended the report of a fire at Peter's address. Although there was no fire, Peter was found unconscious in a park opposite the address. He was conveyed to ED (UHBW) by SWAST, where he was admitted for overnight observations before being discharged the following day. Although there was no safeguarding referral submitted by UHBW, the discharge letter sent to the GP practice included a request for community alcohol services to support Peter. It was noted that SWAST had submitted a safeguarding referral to the GP practice.

[19] Bristol Roads---(Bristol Recovery Orientated Alcohol and Drugs Service), provide support to help adults reduce the harm from alcohol and drugs. Their service includes both outreach and in-reach services.

13.36 On 7 September, Peter did not attend his appointment with DHI. A second appointment was made for 13 September.

13.37 Peter did not attend the DHI appointment on 13 September.

13.38 Sirona specialist falls team engaged with Bristol Care Connect[20] to agree a plan regarding Peter. This included a joint visit being arranged for 26 September and a referral to the occupational therapist if any equipment needs were identified.

13.39 On 21 September, Peter's carer reported that Peter's bank card was missing and about £2,000 had been stolen from his account. Peter was with Female A; both were intoxicated, and Peter would not provide details to the police. The case was closed with no further action; there was no BRAG assessment, but a referral was made to ASC.

13.40 On 26 September, the carer reported to the police that Peter had told them that a female called Female B had taken money from his account. It was noted that his bank card was missing again. Peter denied telling the carer that Female B had stolen his money.

13.41 On the same day, a joint visit was conducted by a Sirona practitioner together with a social worker and a representative from Peter's care provider. Peter was intoxicated. There were several females present. The falls assessment could not be fully completed due to the intoxicated condition of Peter and the females and the fact that none of them would acknowledge that alcohol was a risk factor for the falls. It was noted that although the assessment was not fully completed, the risks in the environment were identified. Recommendations were given to Peter and the care agency. Peter was discharged from the falls service as there were no further actions for them. Information was shared with partners including the GP practice.

13.42 On 14 October, the police returned Peter to his home address after he was found lost and confused in a local supermarket. A BRAG assessment was completed and a safeguarding referral passed to ASC.

13.43 On 31 October, a strategy meeting was held having been arranged by ASC. Concerns considered included mental capacity, alcoholism, and financial abuse.

13.44 On 8 November, Peter attended a face-to-face appointment with the GP. As well as a routine health matter, Peter's use of alcohol was reviewed. Peter declined a referral to alcohol services (ROADS), but agreed to be referred for a liver fibroscan. He also agreed to be referred to a memory clinic due to concerns about his memory impairment.

13.45 On the same day, LiveWest attended Peter's address and made an appointment with him for a door repair. This was scheduled for 6 December. No concerns were noted.

13.46 On 22 November, AF&RS attended three calls to Peter's address, two were false fire alarm calls, the third related to a request from Bristol Careline as a safety chord had

[20] Bristol Care Connect---part of Bristol Council services for adult care.

been pulled. There was no requirement for any further action at any of the three incidents.

13.47 On 25 November, Peter was conveyed to the ED (UHBW) by SWAST having fallen from a chair whilst intoxicated. He had hit his head and appeared confused. A female was present who informed practitioners that Peter was more confused than normal. Peter was discharged after examination; the fall had been two days earlier. There were no referrals made.

13.48 On 15 December, police were called to Peter's address by a female friend of Female B and Female A to report that Peter had cut Female B's hand with a knife. The victim declined to support any police action in relation to the injury. Peter was seen to be in a dishevelled state and did not appear lucid. A BRAG assessment was completed and a safeguarding referral submitted to ASC.

January 2024 to March 2024

13.49 On 17 January, Peter did not attend the appointment for the liver fibroscan. A letter was sent to the GP practice informing them of this.

13.50 On 19 January, SWAST attended Peter's address following a concerned call from two females, believe to be Female A and Female B. As the SWAST crew could not gain entry to the premises, the police were called, and entry was gained. Peter appeared uninjured but confused and intoxicated. A capacity assessment was attempted, and a second opinion was sought from a senior clinician. Peter was considered to have capacity to refuse to attend hospital. Peter was spoken to by the police regarding concerns about exploitation. A safeguarding referral was submitted to ASC and copied to the GP practice.

13.51 On 23 January, police were called to Peter's address as Peter was reporting that Female A would not leave the premises despite being asked to. Female A was advised not to attend the address by police, but no BRAG assessment was completed.

13.52 On 6 February, Peter did not attend another liver fibroscan appointment.

13.53 On 8 February, the GP attempted to contact Peter by phone, but a female answered. The phone was handed to Peter, but he was confused and did not wish to speak to the GP. A home visit was planned for the following week as the GP was concerned about Peter's capacity, home environment and confusion.

13.54 On 9 February, a SWAST crew attended Peter's address after a report from a carer that Peter had suffered a seizure. Peter declined to attend hospital and became threatening towards the SWAST crew. The police had been called but due to the time it took them to arrive, the SWAST crew had left for their own safety as nothing further could be done. A safeguarding referral was shared by SWAST with the GP, police and ASC. The police attended after the SWAST crew had left. They spoke to both Peter and Female B and Peter insisted that Female B looked after him.

13.55 On 15 February, the GP home visit went ahead as planned and Peter was spoken to. He was slow and muddled but the GP assessed that he had capacity although what decisions for was not recorded. A female present was described as his girlfriend. Peter was not willing to address his drinking. The GP had no immediate concerns and as Peter was already open to ASC and safeguarding concerns had previously been submitted, no further referrals were made.

13.56 On 21 February, the police attended a concern for welfare call to Peter's address from a carer. Peter was found to be uninjured and was left in the care of the carer.

13.57 On 22 February, Peter did not attend his blood test appointment. The GP made several calls to contact Peter, but they were unsuccessful.

13.58 On 29 February, Peter was conveyed to Southmead hospital by SWAST having been found unconscious. Despite medical interventions, Peter sadly passed away in mid-March.

14. Appendix 5. Terms of Reference.

Safeguarding Adult Review (SAR) Terms of Reference

1. Introduction

A Safeguarding Adult Review (SAR) is a multi-agency review required by The Care Act 2014: Section 44 and conducted by a local Safeguarding Adults Board (SAB). In Bristol, the Keeping Bristol Safe Partnership (KBSP) fulfil the function of the local SAB. Local SABs have a statutory duty to arrange a SAR when:

a) an adult with care and support needs has died, and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect,

b) and when there is reasonable cause for concern about how the SAB, its members or others worked together to safeguard the adult.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

SAB members must co-operate with and contribute to the SAR to identify lessons learnt and ensure that learning is shared and applied in the future.

2. Subject details

This SAR is commissioned with due regard to the Care Act 2014, in response to the death/serious incident of:

Subject One.

Subject name. George

Date of Death: January 2024.

Subject Two.

Subject name. Peter

Date of Death: March 2024.

Chris Hogben has been appointed as the Independent Chair and Author of the review panel and agreed to commence these duties on 03/06/2024.

3. Purpose and aim of the SAR

The purpose of a SAR is to promote effective learning and improvement to prevent future deaths or serious harm from occurring again. The purpose is **not** to apportion blame to any agency or individual.

The objectives include establishing:

- lessons that can be learnt from how professionals and their agencies work together
- how effective the safeguarding procedures are
- learning and good practice
- how to improve local inter-agency practice
- service improvement or development needs for one or more services or agencies

The lessons learnt are shared by the partnership to maximise the opportunity to better safeguard adults with care and support needs who may be at risk of abuse or neglect.

4. Methodology

The KBSP have decided to use a thematic review methodology that will engage frontline practitioners and partner agency safeguarding leads. The review will be facilitated by an Independent Chair and Overview Report Author. Chronologies collated during the initial scoping phase, together with other relevant information, were reviewed by the Independent Chair to determine the appropriate areas for enquiry. Partner agencies will then be asked to review their own involvement with George and Peter, and to provide a report detailing that involvement, good practice, learning and suggested recommendations. A practitioner workshop will be undertaken to focus on understanding the strengths of the current systems and seeking to identify potential areas for further improvement.

The Independent Chair will then work with the SAR subgroup to develop agreed multi-agency recommendations and key actions for KBSP SAB consideration.

5. Period under review

The panel agreed that the review should focus on the time period between January 2023 and January 2024 for George. The panel agreed that the review would focus on the time period between January 2023 and March 2024 for Peter. Any relevant information relating to either subject from before this time period would also be considered.

6. Panel membership

The following agencies and individuals constitute the SAR panel:

Role	**Agency**
Chris Hogben	Independent Chair/report author.
Statutory Review Officer	KBSP.
DCI, Head of Major Crime and Statutory Review Team	Avon and Somerset Police.
Senior Practitioner Triage/Immediate Response.	Bristol City Council Adult Social Care.
Housing Safeguarding Reviews &Improvement Officer	Bristol City Council Housing and Landlord Services.
Senior Probation Officer	Probation Service.
Operational Lead for Integrated Safeguarding Team	North Bristol NHS Trust.
Named Safeguarding Professional	South Western Ambulance Service NHS Foundation Trust.
Professional Lead Safeguarding Adults	Avon and Wiltshire Mental Health Partnership NHS Trust.
Operations Manager	LiveWest
Deputy Manager.	Bristol City Council Safer Communities.
Vulnerable Adults Manager &Joint Safeguarding Lead	Avon Fire and Rescue Service.
Deputy Designate all age Safeguarding Nurse	BNSSG ICB on behalf of the GP Practice.
Team Leader	Developing Health and Independence.
Deputy Director for Safeguarding (all ages)	University Hospital Bristol and Weston NHS Trust.
Named Lead for Safeguarding Adults.	Sirona Care and Health.
Safeguarding Adults Practitioner	Sirona Care and Health.

7. Chronologies, Individual management reviews (IMR) and other reports

An Individual management review (IMR) and chronology of contact will be requested from the following organisations:

Re George.

- Avon and Somerset Police.
- Bristol City Council Adult Social Care.
- Bristol City Council Housing and Landlord Services.
- Probation Service.
- North Bristol NHS Trust.
- South Western Ambulance Service NHS Foundation Trust.
- Avon and Wiltshire Mental Health Partnership NHS Trust.
- Bristol City Council Safer Communities.
- Avon Fire and Rescue Service.
- Sirona Care and Health.
- BNSSG ICB on behalf of the GP Practice.

Re Peter.

- Avon and Somerset Police.
- Probation Service.
- North Bristol NHS Trust.
- Bristol City Council Adult Social Care.
- Avon Fire and Rescue Service.
- Developing Health and Independence.
- South Western Ambulance Service NHS Foundation Trust.
- Avon and Wiltshire Mental Health Partnership NHS Trust.
- BNSSG ICB on behalf of the GP Practice.
- University Hospital Bristol and Weston NHS Trust.
- Sirona Care and Health.

All chronologies and IMRs should be completed and returned to KBSP.statutoryreviews@bristol.gov.uk by---Monday 11 November 2024.

All chronologies and IMRs should focus on events from:

Subject One---Between January 2023 and January 2024.

Subject Two---Between January 2023 and March 2024.

All agencies required to submit IMRs are asked to respond to the key lines of enquiry listed below.

8. Key lines of enquiry [or] research questions to consider:

1. Alcohol dependency.
2. Self-neglect.
3. Mental capacity.
4. Barriers to engagement with services.

5. Use of Section 42 framework.
6. Deteriorating health conditions including mental health.
7. Domestic abuse.
8. Exploitation including financial abuse.
9. Fire risk.
10. Impact of the COVID-19 pandemic.

9. Subject/ Family involvement

George and Peter's families/next of kin will be contacted by the KBSP at the earliest opportunity. This will be done via letter and sent alongside the SAR information for families leaflet. The partnership will consider whether the first contact should be supported by an appropriate professional who has an established working relationship i.e., a social worker or family liaison officer.

10. Media and communications

All media enquiries must be managed by the Communications Advisor to the KBSP in consultation with the KBSP SAB.

Following an information governance review, the final report will be published on the Keeping Bristol Safe Partnership website.

11. Terms of reference agreed.

The SAR panel agreed these terms of reference at the 2nd panel meeting on the 28th November 2024.

The terms of reference will be kept under review by the panel throughout the review.

Amendments made	Agreed by	Date

15. Appendix 6. Glossary.

A&E	Accident and Emergency
AF&RS	Avon Fire and Rescue Service
ASB	Anti-social behaviour
ASC	Bristol City Council Adult Social Care
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
BCCHLS	Bristol City Council Housing and Landlord Services
BRI	Bristol Royal Infirmary
BRAG	Blue, Red, Amber and Green
CMHT	Community Mental Health Team
CPS	Crown Prosecution Service
DASH	Domestic Abuse, Stalking and Harassment
DHI	Developing Health and Independence

DNA	Did not attend
DWS	Dementia and Wellbeing Service
ED	Emergency Department
ePCR	Electronic Patient Care Record
GP	General Practitioner
HFSV	Home Fire Safety Visit
ICB	Integrated Care Board
IMCA	Independent Mental Capacity Advocate
IMR	Individual Management Report
KBSP	Keeping Bristol Safe Partnership
KLOEs	Key lines of enquiry
LLMHT	Later Life Mental Health Team
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDT	Multi-discipline team
MHP	Mental Health Practitioner
MoCA	Montreal Cognitive Assessment
NBT	North Bristol NHS Trust
NPT	Neighbourhood Policing Team
Police	Avon and Somerset Police
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
Sirona	Sirona care and health
SPA	Single Point of Access
SWAST	South Western Ambulance Service NHS Foundation Trust
UHBW	University Hospital Bristol and Western NHS Trust
WNB	Was not brought