Mr E

Safeguarding Adults Review

Executive Summary

Prepared by the Lambeth Safeguarding Adults Board

June 2019

Introduction:

Mr E a white man aged 62, was born and grew up in the United States, with his parents. He was an only child but had some extended family who he continued to have contact with him after moving to the UK. In the 1980s, he and a business partner opened their own bookshop in London. It was successful for most of the time until Mr E's business partner reportedly took money from the business to spend on a cocaine habit and the business collapsed around 10 years later. Mr E had substance misuse issues of his own however following the loss of his business and then the death of his parents in 2011 and 2014, he started suffering with high levels of anxiety and worsening substance abuse.

Mr E has had periodic contact with mental health services from 1990 up until his death. This generally focused on the issues of anxiety and depression. Mr E had been known to the Substance Misuse Team (SMT) since August 2015 and has been offered information and support to access services to reduce the harm associated with his drinking or to help him achieve abstinence. However, these had not been successful, generally through Mr E's lack of engagement or his explicit statements that he had no intention to stop taking benzodiazepines or to stop drinking. Mr E was a man considered to have the mental capacity to decide to refuse care and treatment offered to him.

On the 17th March 2017**,** Mr E died in a fire at his house.

Findings of this SAR:

The review found that a considerable amount of work had been done by the agencies involved with Mr E and that repeated attempts were made to engage him and to encourage him to accept support. Lambeth Fire Brigade's report indicated that the fire started most likely via an unextinguished cigarette. It is most likely that Mr E's ability to react may have been limited by intake of alcohol and other substances. As such, there was no link established between Mr E's death and lack of action by those involved with him.

There were however still a number of recommendations identified as areas for improvement, which Lambeth Safeguarding Adults Board is taking forward.

Key recommendations:

1. **Communication**
   There needs to be robust communication between agencies when working with individuals whose needs cut across the remit of different services. A clear escalation procedure should be established to agree lead agencies and what support others are expected to offer.

2. **Self- Neglect Policy**
   It should be noted that there was no "self-Neglect" policy in place at the time when Mr E's case was known to agencies. As such there was no clear direction around how to best respond to this. A policy has since been written and it is available on the LSAB website. The Board should consider adopting a multi-agency concerns framework. This would allow

agencies to raise persons of concern, and seek to facilitate a multiagency approach, without necessarily requiring a safeguarding enquiry.

3. **Mental Health Services: Duty to Assess (Care Act 2014)**
   Mental Health Services to be reminded of their duty under the Care Act 2014 to assess where someone is suffering from a mental health condition and using substances. Although we recognise that the assessment can be done by practitioners in substance misuse services, these services will sometimes need input and support from mainstream MH services in order to offer a comprehensive assessment to the person.

4. **Learning & Development:**
   Mental health training needs to ensure that mental health staff understand the interactions between substance misuse and mental health.

5. **Processes within General Practice (GP) Surgeries:**
   Adults with mental health difficulties should be protected when services take the view that those adults must take responsibility for their own health by making telephone calls and/or attending appointments even when the very nature of their illness makes it difficult for them to do so. The Lambeth Safeguarding Adults Board should receive assurance about the process within GP Surgeries when vulnerable adults stop attending or are excluded from GP Surgeries.