Safeguarding Adults Review

Learning from the circumstances of the death of Martin

21st January 1967 – 17th March 2018

Kate Spreadbury

July 2019

Contents

1. Introduction

1.1 Martin's body was found at his address on the 16th March 2018. He was 51 years old. Martin was of White British ethnicity and lived alone. He was last seen alive on the 12th March. His death certificate states that he died on the 17th March, although he may have died at any point between the evening of the 12th and the 16th March. Martin's death certificate says that the causes of death were:

'*1a Lobar Pneumonia with Emphysema and 1b Cirrhosis of the Liver associated with chronic alcohol abuse'*.

Martin was seen by three agencies on the 12th March 2018, the Metropolitan Police, the London Ambulance Service NHS Trust, and a General Practitioner (GP). Adult Safeguarding referrals were made by the police and ambulance trust to Lambeth Adult Social Care and the GP made telephone contact with Adult Social Care (ASC) on the same day that he saw Martin.

Martin's sister and family have been proactive in pursuing further consideration of the circumstances surrounding his death, they are concerned that, following visits from three agencies, Martin was left in squalid conditions, physically frail and with no adequate support.

A Managers Investigation was initially conducted into the circumstances of the case, this was led by Lambeth Council and informed by reports from Lambeth Drug and Alcohol Services, London Ambulance Service and Clapham Family Practice. The Police 'Merlin' Report as well as ASC records were reviewed. The Managers Investigation made recommendations and reported its findings to the Lambeth SAR sub group. The LSAB Chair subsequently accepted the SAR sub group recommendation to initiate a SAR to explore the learning from the circumstances of Martin's death across a wider timescale and with the involvement of all agencies in contact with Martin.

1.2 This Safeguarding Adults Review (SAR) is commissioned by the Lambeth Safeguarding Adults Board (LSAB) in response to the circumstances surrounding the death of Martin. The review is conducted in accordance with section 44 of the Care Act 2014 and the London Multi-Agency Safeguarding Adults Policy and Procedures (London ADASS 2015); and the Lambeth LSAB SAR sub-group Policy and Procedure (2017), i.e. the Lambeth Safeguarding Adults Board has a duty to commission a SAR to review the case of an adult in it's area with needs for care and support *(whether or not the local authority has been meeting any of those needs) if –*

a) *there is reasonable cause for concern about how the SA(P)B, members of it or other persons with relevant functions worked together to safeguard the adult, and*
b) *the adult had died, and the SA(P)B knows or suspects that the death resulted from abuse or neglect…, or*

c) *the adult is still alive, and the SA (P)B knows or suspects that the adult has experienced serious abuse or neglect.*

…Each member of the SA (P) B must co-operate in and contribute to the carrying out of a review under this section with a view to –

a) *identifying the lessons to be learnt from the adult's case, and*
b) *applying those lessons to future cases.*

2. Terms of Reference

The full terms of reference can be found in appendix 1 at the end of this Report.

2.1 The **specific areas of focus** within the Review Report are:

1. To what extent did agencies consider and make use of Mental Capacity Assessments in this situation and are there lessons to be learnt about how it could have been used more effectively?
2. How effectively did agencies communicate with one another and is there evidence of joint decision making and responsibility for the case?
3. Are there any lessons that can be learnt out of the history of the case i.e. were there lost opportunities and/or lack of professional curiosity?
4. How confident are mainstream statutory agencies when it comes working with people who have both Substance Misuse and Self-Neglect issues? Is there any evidence to suggest that a perceived lack of confidence impeded any actions which might have been taken to protect Martin?

2.2 Timeframe: The SAR will cover the time period **1st February 2015** to the **16th March 2018.**

3.Methodology

3.1 The methodology used in this review seeks to promote a thorough exploration of the events prior to Martin's death, whilst avoiding the bias of hindsight which can obscure the understanding and analysis of important themes. Agencies work within complex circumstances, and a systemic approach to understanding why people behaved as they did, and why certain decisions were made, is essential if learning is to be derived from the Review.

3.2 Activities undertaken during the Review process have included: collation of chronologies, individual agency reports, examination of documentation as appropriate,

identification of key episodes, exploration of these episodes and the lead Reviewers' findings through two learning workshop events with the agencies and personnel involved with the case.

3.3 The following agencies have contributed to the Review:

Lambeth Adult Social Care
Metropolitan Police Service
London Ambulance Service
Clapham Family Practice
London and Quadrant Housing Association
South London and Maudsley NHS Foundation Trust Lambeth (SLaM) Addiction Services: Shared care team.

Agencies attended a learning review in December 2018 to develop the initial themes identified by the lead reviewer. The agencies were:

Lambeth Adult Social Care

London and Quadrant Housing

Metropolitan Police Service

Lambeth Council Substance Misuse team

South London and Maudsley NHS Foundation Trust (SLaM) Addiction Service

The lead reviewers' findings were developed at a second workshop held in March 2019 Involving the following agencies:

Lambeth Adult Social Care

London and Quadrant Housing

Metropolitan Police Service

South London and Maudsley NHS Foundation Trust (SLaM) Addiction Service

Clapham Family Practice

Lambeth Clinical Commissioning Group

4. Involvement of Martin's family

4.1 Martin's family raised concerns about the circumstances in which Martin died on the 3rd April 2018. A Manager's investigation as detailed in 1.1 above was undertaken to clarify the known facts. Martin's family were consulted as to their wishes prior to the Lambeth SAB Chair considering the recommendation to commission a SAR.

4.2 Family participation in the SAR: A meeting was held between the lead reviewer, Martin's mother, sister, step father and Martin's sister's partner in November 2018. The family reviewed the terms of reference for the SAR and gave their own thoughts and questions to the lead reviewer. The family gave a statement regarding Martin's background and their experiences in March 2018.

A second meeting will be held with the family to review the SAR draft before final submission to the Lambeth SAB.

The family will also be invited to comment on the final SAR report pre-publication and its recommendations.

5. Relevant history prior to the time in scope

Martin was close to his sister and mother, and enjoyed time with his nephews, he had a circle of friends, some dating from his early youth. His friends have described many occasions when he supported them during times of crisis and depression, he was a kind person. He got on well with his neighbours and was involved in the life of the block of flats in which he lived. His family describe him as gentle. In the last years of his life he looked unwell, and in his last year appeared to have actively cut off connections with his friends and family. His closest friend was left bewildered that he did not attend his wedding or keep in touch. It seemed to his family that he had "given up" and was hiding away and drinking.

Martin started drinking when he was 16 or 17 years old. He had been bullied at school and in his teens became part of a peer group which included drinking a good deal of alcohol. He began to disappear from home for a day or two at a time, frequenting the gay clubs and gay scene in London and continuing to drink alcohol there. In his early 20s Martin began a relationship with x which gave him happiness and stability. During this time, he was able to enjoy his family including his young nephews. Martin worked as a chef in various settings including a care home, and he volunteered for London Gay Switchboard.

X had to return to his home country to undertake national service and the relationship with Martin faded. Although Martin had other relationships none seemed as serious or stable as his relationship with x. Martin began to drink heavily again. Around 2003 – 2004 he was attending the SOBERASS service in Luton and taking Antabuse. He was becoming badly affected by alcohol use, he had hallucinations and episodes of unconsciousness. His sister was very involved in helping him to get sober during this time. He attended a residential detox hospital in Houghton Regis near Dunstable.

Despite his own and his family's best efforts Martin continued to drink. He would stop drinking for several weeks but then relapse. He would try to stop in relation to events which may have led to a realisation of his situation, e.g. he would have a legacy from his mother but it would be managed by other family members as receiving a large amount of money may lead to his death through drinking. Martin told his sister that he wondered if he had autism, he couldn't understand people or how to live. Alcohol was initially an emotional

support for him which had led to chronic addiction. Martin fabricated events, potentially to cover for drinking and to subsequently avoid family contact. He had a friend who appeared to have constant health crises that he had to miss family occasions to care for. Martin's fabrications were also quite dramatic, telling friends his step father had died and telling his housing association that his sister and parents were dead. This emerged when his sister phoned his housing association concerned that his tenancy was about to end, she was told that she must be an imposter as he had no family.

Martin last saw his family in April 2017. In the year before he died he did not see his friends. He seemed to be hiding away.

Martin lived in a 'general needs' block of flats managed by London and Quadrant (L&Q) Housing Trust. He did not have any services from the Housing Trust. At the beginning of the time period consider by this Review Martin was engaging with services which could support him to stop drinking alcohol. He was beginning to work with a South London and Maudsley NHS Foundation Trust Addiction Services (SLaM) GP surgery based worker, a 'shared care' worker. The shared care worker could offer weekly or bi-weekly 'key working' sessions. People who are suitable for community detox, i.e. withdrawing from alcohol at home, can arrange this via their GP, and can also access a range of groups and advice services on offer. The GP route offered a realistic choice to people who might not get down to the main centre at Lorraine Hewitt House in Brixton. There are shared care workers, who can be nurses or social workers, in forty-four GP surgeries in the area. For further context, it should be noted that only 10% of people with alcohol problems present to services, others stop drinking independently. Martin had tried both routes in the past and appeared to understand well that he needed medical and psychological support to stop drinking. He was also attending a harm reduction group which supported people who were uncertain of their next steps, for example whether to go forward with detox, and to help them build skills to control their drinking.

6.Key Events and Analysis

6.1 January 2015 – May 2016

This part of the analysis of key events concerns Martin's struggle to retain the motivation to recover from his alcohol addiction.

6.1.1. In **October 2014** Martin was referred to the 'shared care' substance misuse service by his GP. He attended the first session with his shared care keyworker on **January 29th 2015**. He reported that he was drinking 16 – 20 units of alcohol a day. This would be equivalent to up to two bottles of wine or 8-10 cans of larger or beer per day. Martin requested an inpatient detox and rehabilitation programme. The key worker made a referral to the Lambeth Adult Social Care Substance Misuse Team (SMT) for funding for this.

SMT is a small team of three social workers and a manager based at Lorraine Hewitt House. An individual is referred to this team if they want residential rehabilitation after detox. This

is provided either through a funded day programme or funded residential treatment, both are abstinence based. SMT worked with someone if they wanted in-patient detox immediately followed by rehabilitation, any individual seeking detox only would not be referred to SMT. Residential detox meant giving a person medication in a safe centre, to help bring them off alcohol, this may take up to ten days. The person's medication and health were monitored and they took part in "low level" group work, focusing on advice and education. Residential rehabilitation was a minimum of twelve weeks, and there is no break between detox and starting the rehabilitation programme. Residential rehabilitation provided a therapeutic environment, helping people to learn coping strategies and life skills. Martin had not worked for many years at this point in his life. There were also therapy sessions looking at what led the person to misuse substances and how they might recover from any harm or trauma.

Prior to agreeing the need for residential detox and rehabilitation and the funding for this, the person would have a Community Care Act Assessment (CCA) to explore the options for detox. Martin was also referred to the Harbour , a day service which offers weekly meetings, and he was referred to the pre-detox groups, necessary for him to attend on three consecutive occasions to demonstrate his motivation to engage in the challenging process of rehabilitation post detoxification.

As well as seeing a shared care keyworker Martin had also been attending a Harm Reduction group, a commitment he continued to keep up for the whole period. Now that he had asked for residential detox and rehabilitation his care was reviewed at a shared care multi-disciplinary team meeting (MDT).

6.1.2 Martin attended the first pre-detox group on the **5th February**. He appeared to be engaged in moving forward to a healthier lifestyle. He had an appointment to see the SMT social worker on the **11th February** to begin the Community Care Act assessment, together with an appointment at the "Every Pound Counts" benefit advice service for a benefit check and advice. Martin did not attend his appointment with the social worker on the 11th February but he did see a nurse at the GP surgery that day, and had blood tests for liver function, his blood pressure tested and weight recorded.

Martin saw GP1 on the **16th February**. He needed a new "Fit Note" (a statement of fitness to work necessary to access benefits). Martin had not worked for some time due to a diagnosed "Alcohol Dependence Syndrome" He was issued with a fit note covering the February 2015 until the 16th April 2015 period. The fit notes generally covered a two-month period. Martin regularly attended these appointments every two months but did not take up the GP's regular offer of a consultation in between these times. Martin stopped seeing his GP in **October 2015** when he was no longer required to provide a 'fit note' to claim benefits.

Martin missed the second pre-detox group in February. He phoned the SMT social worker to inform him that he could not attend the pre-detox session two because of a 'heavy' night

drinking the night before. The social worker explained that the pre-detox groups were 'closed groups,' they had to be attended consecutively, Martin would need to wait until the following month to begin again and must attend all three sessions. He was offered another appointment on the 23rd February with the SMT social worker to complete the CCA assessment.

The multidisciplinary team made efforts to re-engage Martin at this point. He had an extended 'check in' session after the Harm Reduction group on the **23rd February**, he was also telephoned by his shared care keyworker. He was referred to the March pre-detox group, advised to attend Alcoholics Anonymous (AA) meetings and to continue attending the recovery space groups.

Martin attended the next appointment with the SMT social worker on the **23rd February** and they began the CCA assessment together. Another appointment was booked for both to finish the assessment on the 2nd of March. Martin attended the appointment with his shared care keyworker on the **27th February**, the following entry was made in his GP notes by the keyworker:

'Alcohol dependence syndrome (Review) Recovery: Booked on Pre-detox group for March. Text to remind him. Has been attending harm minimisation group at Recovery Hub. Not interested in AA. Have suggested he attends Recovery Space for massage and to check in with me each week. Alcohol:4-5 pints lager 5% daily. Psychological/ Physical Health: Feeling okay emotionally. Not depressed. No issues physical health. Risk: No risks or concerns. Medication: Getting Thiamine and Vit B compound'.

6.1.3 Martin phoned to cancel the appointment to complete the CCA assessment on the **2nd March**. He said that his mother had an accident and was planning to travel to see her. He was offered another appointment for the 9th March.

Martin was due to attend the first of the next set of three pre-detox sessions on the 5th March but did not attend. His non-attendance was not followed up, but he telephoned the SMT social worker on the 9th March and left a voicemail to inform him he was too ill to attend the appointment to complete his assessment '*at 2pm'*, although appointment was at 10am. No alternative date was given to him for another appointment.

On the **11TH March** Martin was discussed at the MDT meeting. The meeting discussed Martin's nonattendance of the last pre-detox group and noted that he did not attend the CCA assessment appointment on the 9th March. The MDT referred this information back to Martin's shared care key-worker. On the 17th March the SMT social worker telephoned Martin to re-arrange a second appointment for the **19th March** to complete the CCA assessment. Martin attended and the CCA was completed. Martin was re-referred for the April detox groups.

6.1.4 Martin was given another appointment with the social worker for 11:30 am on the **2nd April** as he had the first pre- detox group the same day. Martin also agreed to resume his

attendance at the recovery group which had lapsed. His shared care worker was to arrange a detox assessment appointment with a doctor at Lorraine Hewitt House with a view to potential detox admission at end of April. This appointment does not appear to have been made, the report author notes that the *'Patient had disengaged with shared care worker. No assertive re engagement work detailed in notes from shared care'.*

Martin attended the first April pre-detox session and it is recorded that he '*actively participated'*. He attended session two on **9th April**. However, on the **16th April** Martin telephoned the SMT social worker ten minutes before start of the pre detox group session three, he said that he was unable to attend, his mother was unwell and he needed to be away for at least one week.

On the 24th April the social worker rang Martin as agreed. Martin said that he would not be returning to London until the 29th of April. He attended the Harm Reduction group on the **1st May** and saw the social worker afterward. Martin reported that he had self-detoxed while staying with his parents. He intended to return to his parents again until the 7th May. The social worker advised Martin to consider alternative medicinal support to aid abstinence via his GP, and to continue to attend the groups on offer, his inconsistent attendance since November 2014 was also discussed. Martin was encouraged to try the Improving Access to Psychological therapies service (IaPT) as he reported a low mood, he was also given details of Self-Management and Recovery (SMART) groups in the area.

Martin's family have reported that Martin was not at home with them during this time. It is more likely that he was struggling to engage with his addiction issues and used the family visits as a way to avoid engagement for a time.

6.1.5 The social worker agreed a further appointment with Martin for the 7th May, but Martin called to cancel this saying he was unwell, he denied this was alcohol related. He cancelled his next appointment for booked the following week too, saying that he was still ill. Martins' social worker called him again on the 21st May, Martin acknowledged that the last two cancellations had been alcohol related and arranged to meet the social worker on **27th May**. He attended and engaged in an "*in depth session reviewing past engagement and future plan. Currently alcohol dependent drinking 4 litres of cider daily. 2-week binge recently. Social life embedded in alcohol use. Requesting inpatient detox and community aftercare within consortium group programme. To be seen by doctor at Lorraine Hewitt House regarding aftercare medication support once abstinent. Martin agreed to attend the SMART Recovery group 2:00 pm Wednesdays at Aurora project and the Harm Reduction group Fridays at the Recovery Space to prepare him for detox. While at the Recovery Space he is to make himself known to the Community Link Service staff there as this too a potential source of aftercare support. Agreed to link in with shared care worker again and made another appointment to see him on the 9th June".*

6.1.6 At the MDT meeting of **3rd June** Martin was referred to in house doctor and shared care worker to re-engage him in planning for detox and recovery. Martin did not attend the

appointment of the 9th June and made no contact. The lack of attendance was not followed up with a phone call but discussed at the MDT meeting on 10 June and a plan was made to offer him one more appointment on the 18th June. If he did not attend, he would be discharged from the substance misuse team and would return to 'shared care' until he was ready to engage. A letter was sent to Martin outlining this plan.

6.1.7 Martin saw GP2 on the **17th June** for a new 'fit note'. The GP used this opportunity to follow up his progress, Martin said that he was waiting for residential detox and was engaged in counselling and other treatments. Martin did not attend an appointment with the social worker on the 18th June. He was therefore discharged from the substance misuse service and referred back to shared care. Shared care is able to refer back to the substance misuse team quickly. A letter was sent to Martin informing him of this decision.

On the **24th June** the shared care keyworker called Martin and explored his attendance. Martin felt that staff did not understand how much was going on for him. He was reassured by the shared care keyworker but the requirement for his regular engagement was reinforced. The shared care key worker would review his attendance at the recovery space due on the 2nd July and would discharge him on irregular engagement. Martin attended the recovery space on the **2nd July**. But he did not attend the recovery group on the 9th July and did not attend the Harm Reduction group as agreed. No further follow up contact was made by the shared care worker.

6.1.8 The completed CCA assessment was uploaded onto the adult care database on the 17th July. Martin had said that he no longer wished to have residential detox, and he had no other eligible care and support needs. It was noted that he was to continue to be supported by his shared care worker to work towards detox. Martin did attend the harm reduction group on **27th July** and the **28th August**.

6.1.9 Martin saw GP 1 on the **14th August**, his fit note was renewed until mid-October 2015. Martin told his GP that he was '*awaiting detox, still attending counselling and AA.'* GP 1 gave advice on smoking cessation and encouraged Martin to come in for review before the next fit note was due. This however proved to be Martin's last visit to his GP. In **October 2015** DWP agreed Martin's employment and support allowance and he was no longer required to attend the surgery for fit notes.

Martin appears to have retained some engagement with the shared care keyworker. Martin attended a check in session with his shared care keyworker on the **11th September 2015** and on **12th November** he was referred to the December pre-detox group by the shared care keyworker. He was now requesting a day programme following in patient detoxification. Another appointment was booked with him for two weeks but he did not attend. This was his last known contact with addictions services.

6.1.10 On the **6TH May 2016** Martin was discharged from the shared care service "*unplanned drop out of service from the 12/11/15 when last seen by Addiction services*". Martin had no further connections with the GP surgery after this time.

6.1.11 During this period Martin regularly took action when concerned about either the repair of his flat or repairs in communal areas. He made fourteen requests for repairs in 2015, including two for repairs needed in communal areas. He is reported by L &Q as being involved in community affairs at the flats at that time. He made two requests for repairs to communal areas in 2016 and three requests for repairs to his flat.

6.2 May 2016 – May 2017 No agency contributing to the SAR had contact with Martin during this time. His family last saw him in April 2017. Martin made one request to L &Q for a repair to his flat in April/May 2017 and no further requests after that date.

6.3 Analysis January 2015 – May 2017

6.3.1 Communication: Martin appears to have had generally good support from the addictions services involved. At times assertive engagement with him was not immediately followed up by workers but attempts at re engagement happened soon afterward. GPs 1 and 2 do not appear aware that Martin had dropped out of engaging with services, and so opportunities for enquiry and respectful challenge of Martin's account of his progress may have been missed. Although the discussions between the shared care keyworker and GP 1 and 2 are not recorded it is reported to be likely that the shared care keyworker would have been communicating with the GP regularly as the key worker was based in the same surgery. The shared care key worker had access to Martin's blood tests. The GP and keyworker used the same recording systems. It was still possible for information to be missed, for example in April 2015 Martin told the SMT social worker that he was out of London but attended the GP surgery for a fit note. This may have given opportunity to challenge Martin's avoidance behaviour, but it must be remembered that Martin was ultimately the decision maker about whether to keep engaging or not. Discussions between professionals should have been recorded, and attendees at the first Review learning workshop suggested that recording practices have now improved. The local authority SMT and SLaM colleagues were based in the same building and reported to be '*talking all the time'*. Should informal communication fail then the multi-disciplinary team met regularly to discuss MARTIN, at the time this involved a consultant psychiatrist, junior doctor and the SMT members, but not Martin's GP.

6.3.2 Barriers: A potential barrier to Martin getting to residential detox and rehabilitation may have been the requirement to attend three "pre-detox" sessions before beginning the programme. The rationale for this process can be appreciated, the twelve-week programme was said to be "*intensive*" and some preparation would be needed to engage in such a setting. However, such arrangements can also become a way of testing and re-testing motivation, and the motivation of some individuals who have addictions is not consistent. Martin appeared to move quickly between stages of motivation during this period, those of

"preparation" and "action" and then relapsing (*Prochaska and DiClemente's (1982) Stages of Change Model*). The SMT social worker and shared care key worker were both active at different times in engaging and challenging him to attempt to promote his motivation. We cannot be aware of any other factors in his life at that time. Unlike his previous detox and rehabilitation programme (*see section 5 Relevant History*) Martin's family were not involved in supporting him. His assertions that he had to support his mother or had detoxed at his parent's house could not be challenged or seen for the avoidance behaviour they were.

Attendance three times at a group over a month-long period appears to have been impossible for Martin to achieve. Currently people no longer need to attend a pre-detox group, the group could no longer be resourced, and the shared care key worker now does preparatory work with the individual on a one to one basis. Entry into detox is a faster process, addiction services have no evidence as to how much difference this makes to individuals, but not having to attend three consecutive groups would have meant one less barrier for Martin. Martin is reported to have changed his mind frequently regarding which type of detox he needed, currently the determination of whether a person needs in-patient or community detox is based on a risk assessment carried out by a SLaM doctor. This risk assessment could have provided firmer ground on which to encourage Martin to think through his options.

6.3.3. Relationship with GP surgery. Martin appears to have had a good relationship with his GPs who he saw regularly. GPs 1 and 2 demonstrated a commitment to supporting him at this time, offering appointments and encouraging Martin to keep in touch, however Martin was obliged to see his GP at least every two months in order to obtain a 'fit' note to access benefits. Once he no longer needed to do this, he stopped attending the surgery, and opportunities to challenge and support him were lost. The GPs were able to assess Martin's physical health during this time, via various tests including blood pressure and liver function. He was not diagnosed with cirrhosis of the liver at this time and may have been unaware of his health status at the time he died.

6.3.4 Community involvement. Until May 2017 Martin appeared to be taking an active interest in his personal and communal accommodation. This active involvement began to trail off during late 2016 with the last request made to his landlord almost a year before he died. It is not suggested that the landlord should have identified and acted on the change in the pattern of reporting, but does indicate to us in hindsight that this may well be the date at which Martin began to withdraw from his life and networks.

6.4 May 2017 – February 2018

6.4.1 In **May 2017** a GP from the surgery wrote to the Department of Works and Pensions (DWP) giving Martin's medical history for the purpose of assessment of entitlement to benefit. The letter stated that Martin had not been seen since 2015.

6.4.2. On **20th November 2017** the GP surgery received a letter from St George's Hospital casualty department, stating that Martin had presented with an alcohol withdrawal seizure and was advised to see his GP for follow up. Martin did not see his GP, and no follow up was carried out.

6.4.3 On the **4th February 2018** a 999 call was received for an ambulance to attend Martin's address. It is documented that a neighbour made the call and that they did not want to be identified to Martin. The neighbour reported that Martin had blood all over his clothes, bloody eyes and had been in a bad way for a couple of days, possibly intoxicated, he kept collapsing. Martin's neighbour let the ambulance staff into the entrance of the flats. The ambulance staff knocked on Martin's door and he answered after a while. He said that he had fallen the previous day and did not want any help and that he would ring for an ambulance if he needed one the next day. He denied the ambulance staff access to the property and declined all clinical observations. The ambulance staff documented that Martin had a possible fractured nose and a cut to his left eye. He did not appear intoxicated and appeared to have the mental capacity to make these decisions about this own welfare. He was left at home by the crew with the advice to ring an ambulance if his condition deteriorated. The GP surgery have no record of the ambulance attending, they may not have been made aware of this.

6.4.4 On the **9th February** an email was received by L&Q from a neighbour of Martin:

"To whom it may concern, I've recently tried to contact the resident officer for this property, however I didn't get through. I'm having real concerns for my neighbour at Flat x, Martin. His behaviour is starting to deteriorate, whether that be him drunk during the day and evening. I'm also sure he is using his corridor as a place to faeces. The main corridor either smells of 'pooh' or other waste, it is becoming difficult to live with. I'm worried about his health and mental health! I've talked to other neighbours in the block about his behaviour and the smell eroding from his property- which is very bad. Other neighbours on the street have also complained about him emptying the bins on the floor on a weekly basis. Please can you look into this as it is becoming a serious problem".

Property Managers are employed to oversee the physical environment at L&Q premises. They are responsible for the upkeep of the shared general areas of the accommodation. The L&Q Property Manager visited the property but could not get into the flat. He "*found nothing unusual*" in the area around the flat but agreed to monitor the situation, emailing the neighbour to update her. L&Q believe that they made an adult safeguarding referral, "*we raised a cause for concern*" to Adult Social Care. The first email sent to Lambeth social services went to the children's duty team, the duty team sent it onto Adult Social Care (ASC) copying L&Q in, it was received by ASC on the **21st February**. The email from L&Q said

"Neighbour living in the same block with Martin are concerned about his mental health, deteriorating behaviour and the smell of poo coming from his corridor. Apart from being

drunk most of the time, neighbours on the street are complaining about him emptying their wheelie bins on the floor on weekly basis for no apparent reason.

I am concern about his wellbeing. Is Martin known to your Team?"

ASC checked on the Mental Health database, Martin was not known to mental health, and no response was made to the L&Q referrer. A contact referral form was completed by ASC and badged as '*awaiting further information gathering'*. It is unclear what this information was or who it would be gathered by.

6.4.5 On the **21st February** the GP surgery received a letter from NHS 111 "*Patient had a fall and cut back of head. NHS personnel wanted to send an ambulance to send him to hospital but patient refused saying he would have no way to get back home, not to lecture him and that he would call back if got worse. Martin terminated the call".* The GP surgery did not follow up this letter.

6.5 Analysis May 2017 – February 2018

6.5.1 Engagement: Martin was disengaged from all services, and no services engaged with him. GPs 1 and 2 were no longer involved in his care, and the GP surgery did not exhibit any curiosity about Martin's lack of engagement or the two reports they received about his health. Any actions the surgery could take may well have been ineffective, Martin had not previously shown interest in engaging with his GP unless he needed a fit note. However, during 2017 Martin was so isolated from services, his family and friends, that a letter or phone call from his GP might have had some impact on him. We cannot know this however. How much should we expect from GP surgeries in terms of patients who are avoiding engagement? GPs have a large number of registered patients and will not know them all. GPs 1 and 2 were not working at the surgery at this point, the days of the 'family doctor' are gone and patients see many different doctors. A personal relationship with a GP is the element that can make a difference to a patient's engagement, but the expectation is that the patient will present themselves to the GP. GP responses are usually reactive to a patient request or crisis, and there appears to be no system to track and alert when a patient has been seen in ED or by LAS on more than one occasion in a short space of time. How a GP would respond to this information is uncertain, people may not respond to a letter or a text, further thought is needed as to how GP surgeries can be aware of patients who appear to be experiencing a rapid decline in health, and what the GP should be expected to do about this.

Signs of a serious deterioration in Martin's health were beginning, and it is uncertain whether he was trying to detox himself or whether his physical condition was now affecting him badly.

6.5.2 Concern referral; It was noted that the email sent to ASC by L&Q asked if the Martin was '*known*' to services. It is unclear how L&Q intended this email to be received, they

believed it was an expression of concern about Martin's welfare. ASC appear to have interpreted the email literally, ascertaining that he was not 'known' to mental health services. The email was not clearly marked as an adult safeguarding concern. ASC recorded that they were '*awaiting further information gathering'* but did not respond to the L&Q referrer.

Had L&Q received a negative response from ASC their next step could be to refer him to the Lambeth 'Vulnerable Victims' Panel as someone who was behaving in an 'antisocial 'way. The Panel facilitates multi agency action plans to promote the best outcome for the welfare of the person exhibiting anti-social behaviour as well as those who are affected by it. This could have been an avenue whereby Martin's needs could have been further exposed and understood. The Panel is held monthly with the Panel coordinators, Lambeth Council housing and homelessness service, inviting the appropriate agencies to attend. L&Q were in an information gathering stage and waiting for a response from ASC. ASC has no agreed protocols about when and how referrers should be responded to regarding information gathering enquiries.

L&Q report that their staff are now more confident about sending concerns about adult safeguarding to local authorities. L&Q merged with the East Thames Housing Association in April 2018 and now have a 'supported housing arm' (L&Q Living). As part of these changes L&Q updated their adult safeguarding procedures and now provide face to face training in adult safeguarding to their staff via an external provider. Although staff must be guided by the procedures of the local authority they are referring to, L&Q have produced a ten-step guide to support staff with this. When a referral is made to local authorities regarding a safeguarding concern there is an internal log which allows the L&Q Safeguarding Manager to track concerns and chase them up with their own staff and/or the local authority as appropriate. All Property Managers have had adult safeguarding training to enable them to identify early signs of concern. The email from L&Q about Martin did not constitute a safeguarding referral but was an expression of concern with an attempt to share information about a vulnerable person who was having an effect on others, the email should have elicited a response from ASC.

The ASC Initial Contact Service receives all contacts coming into adult care, not just adult safeguarding concerns and is an extremely busy service. During the time in scope the team received referrals in several ways, e.g. via email, telephone, through the council's own database systems, through council members enquiries etc. The service was receiving an average of 1530 emails a month.

There is pressure on all council services, and indeed all statutory and GP services at the moment, as there was during the time that Martin was referred to ASC in both February and March 2018. Services under pressure must take steps to preserve the quality of decision making, and we will discuss this further in 6.6 below.

6.6 The events of March 2018

6.6.1 On the **11th March**, another of Martin's neighbours had not seen him for ten days and was concerned, she knocked on his door that evening and he answered feebly, calling out that he could not come to the door. The next day she telephoned L&Q and told them that she was concerned for Martin, he had not been able to get to his door the night before, and she reported that the smell from his property had been there for seven weeks. L&Q noted that Martin did not have a mental health 'icon' on his notes and so agreed to arrange another visit from a Property Manager. The neighbour knocked again on Martin's door and was concerned that there was no answer so phoned the police.

6.6.2 The police attended at 9.30 am on the **12th March** and got no answer from Martin despite knocking loudly, they therefore used powers under Section 17 of the Police and Criminal Evidence Act to force entry as they feared that Martin had collapsed inside.

The police record that:

"*Upon entry the flat was in utter disarray. There were human faeces smeared on the floors and walls. The kitchen had food left on the side which had accumulated mould where it had been left for so long. Martin was found lying on a soiled mattress in the bedroom with dirty clothes and rubbish around him. The fridge bore no signs of any fresh food. Martin had some water left on the floor but this was in a dirty old bottle. When asked about his medical history he could not be specific enough to inform officers of any ailments he has but stated he had recently been in hospital with a fever but was advised to go home and have plenty of rest. Martin was dirty and in dirty soiled clothing. There were signs of blood or dried vomit around his mouth. It is evident to officers that Martin is very unwell. There may be substance misuse and physical ailments. Martin is in need of support and help. This is something that cannot be left*".

One of the officers who attended remembers that his general impression was that Martin looked as if '*he had given up on himself and had stopped looking after himself*'.

6.6.3 The police called an ambulance at 10.03am which attended at 11.11am, within the NHS England response time for patients exhibiting Martin's level of clinical need but leaving the two police officers in attendance of a man they believed to be very unwell. Martin declined both clinical observations and conveyance to a hospital and so the ambulance personnel, as the Decision makers in this instance, assessed his mental capacity to decide on these matters, using the LAS mental capacity act tool. The crew have recorded that Martin was able to communicate his decision effectively, that they had a "*rational*" conversation with him about the pros and cons of what they were proposing, that he was able to understand the principle risks and benefits of what was proposed, he was able to retain this information for long enough to make a valid decision, could use and weigh the information and, in the opinion of the crew assessing, could understand the *'reasonably foreseeable consequences of receiving the proposed treatment*'. In their mental health risk assessment, the crew recorded that, although Martin exhibited no hallucinations or indicators of a severe mental health condition, he was behaving '*inappropriately or bizarrely'* to the

situation and was '*overly quiet and withdrawn*.' He was self-neglecting and living in squalor, said that he had no next of kin or family support, reported regular excessive use of alcohol and was disengaged from services.

LAS report that

"*Martin would not allow clinical observations to be undertaken, following a visual assessment the ambulance staff's suggested course of action was for Martin to be conveyed to hospital for assessment and treatment. Martin was complaining of a 3-month history of diarrhoea and was living in squalid soiled conditions, he was self-neglecting his health and hygiene causing significant concern to the ambulance staff, police officers and his neighbour. Martin declined to be conveyed to hospital".*

6.6.4 The police left the scene but recorded their observations (as above) on a MERLIN form. This was subsequently BRAG rated as Green by the Public Protection Unit (PPU) and sent to Adult Social Care at 7.55 am the following day, 13th March. The PPU gave the following rationale for the Green rating:

"*based on the London Ambulance Service attending and deeming the subject to have capacity and that they are arranging his GP to attend. However, the description of the subject and his living conditions are concerning and do not seem to be the sort of environment an ill person should be in if they are to get better?? The subject is known to Mosaic re substance misuse and it is not known if this is a factor. Although the subject's GP is to attend today, the subject may benefit from support from other agencies. URGENT ACTIONS REQUIRED: None CHECKS TYPE: IIP and pass to Adult Safeguarding"*

6.6.5 The ambulance crew in attendance were concerned about Martin and therefore contacted a GP from the surgery Martin attended. The crew's intention in doing this was to try another approach to see if Martin could be persuaded to go to hospital. GP 1 who frequently saw Martin was on a planned absence in 2018. The GP who attended read through Martin's records before visiting the flat. The LAS crew met the GP at Martin's flat and have recorded that the GP stated that he would contact the Mental Health Service that day. The LAS staff left but telephoned their concerns into the LAS headquarters so that a Safeguarding concern could be raised with Lambeth Adult Social Care.

The LAS referral said that Martin was an adult with care and support needs who was unable to protect himself from harm, he was not at immediate risk of significant harm, and was self- neglecting. An account of the concern was given in the referral:

"*Martin lives alone and has been having several months of diarrhoea which has not been treated.*
There is faeces all over the flat, walls, bed and mattress, the flat is dirty and cluttered but not hoarding, there is rotting food in the kitchen. The bed is broken.
The flat is cold ? the heating is not working.

M has poor personal hygiene with faeces on his face, Martin has not been eating, he has ? poor mobility
Martin will need carer's for personal hygiene, domestic chores, cooking and shopping.
Martin has refused the hospital and the GP - GP visited Martin when the crew were on scene.

The crew report that Martin gave consent for them to make this referral. The referral was received by Adult Social Care the same day, **12th March**.

6.6.6 The GP recalls that LAS made a lunch time call to the surgery, the LAS crew were at a flat close by, *'they had tried to persuade a man to go to hospital but he refused*'. When the GP arrived the crew were standing outside, concerned, they felt he needed to go into hospital. They are reported to have been relieved that a GP had been able to attend so quickly.

The GP went in to see Martin. He was reclining on a mattress on the floor. The GP said that he needed to go to hospital, Martin said '*I am fine'* that he was getting out and would pop into the surgery the next day. There were no bottles of alcohol in evidence but lots of bottles of Yazoo. Martin said that he "*couldn't be bothered*" to go to hospital that day. The GP undertook a mini mental examination to ascertain if Martin had any cognitive impairment, as he knew that he had previously had issues with alcohol addiction and may have had some dementia, possibly alcohol related or other form of impairment of or disturbance in the functioning of his mind or brain. This is the first stage of any mental capacity assessment. Martin appeared to have no such impairment. The GP recorded in Martin's notes:

"Living in squalor, not been out of house for several days. Not drinking alcohol (no evidence of bottles in flat), says has had diarrhoea for over a month, no vomiting, says he feels very weak. Living off milk shakes. Procedure - capacity problems, understands risks. Examination- No obvious capacity problems, understands risks from not receiving further treatment, knows what day it is, prime minister, address, date of birth. …a lot of staining on mattress - teeth badly stained? Hematemesis as well as diarrhoea (does not admit to this). very pale – anaemic, not prepared to stand - lying in bed whole time, good eye contact, no slurring. Comment: refused to go to hospital. says wants to relax, says will go in in a couple of days. Will phone ambulance, says does not want to see any more doctors today. Had alcohol withdrawal seizure last November. Known to CLAS (shared care) team".

The GP did not think that Martin seemed near death, he was very shocked to hear that he had died. Martin also told the GP that he would come into the surgery the next day, the GP felt this would be the best agreement he could get from Martin at the time. He remained very concerned about Martin however. The GP had not experienced a situation like this before. He consulted a colleague when he returned to the surgery who advised phoning the mental health team. He did so and was told that Martin was not open to them and had no

diagnosed mental health issues. He was advised to phone Adult Social Care which he did the same day, he said that he telephoned with the intention of getting Martin to be seen urgently. He recalls that the service sounded very busy and the conversation was rushed. The GP recorded that he spoke with a member of the ASC Initial Contact Service duty team and it was agreed that

'*since he has no immediate mental health/mental capacity problems, that he has no learning disability, that he has no mobility issues, and that he is choosing not to accept help from the healthcare teams, Lambeth ASC will view this as an adult safeguarding issue and will visit to assess his situation. (The duty worker) pointed out that this may or may not be this week. The patient claimed that he would go out to get food later today or tomorrow and is drinking water"*

6.6.7 The process in ASC for adult safeguarding contacts is that a 'concern' is screened to look at the information already held and with an expectation that the practitioner should try to make contact, usually by telephone, with the person to gather their views about what they need or want, and how ACS can offer support. If the practitioner cannot contact the person, they should go back to the referrer to ask for their support in completing the screening. If urgent, they may refer on to partner agency – e.g. GP – to ask if they have had contact with the person. There is then a process of information gathering to inform risk assessment and determine the next step. The initial contact service (ICS) at ASC has hundreds of "concerns "per month to make initial enquiries on and respond appropriately, using the Care Act s42 duties when proportionate to do so. The ICS also hold cases in their team, undertaking case management with service users, trying to get them to a place where they are willing to engage with support. This has the effect of creating a back log in the team and risks new concerns not having the attention they need. The ICS service was, and is, busy and can be overwhelmed, especially if staff are sick or leave. It is understood that the service is currently being remodelled.

6.6.8 The GP asked if Martin had attended the surgery the next time he was in work, two days later. He had not, the GP wondered what to do, should he return to the flat and how would he get in? It seemed to him disproportionate to ask the police to forcibly enter every time Martin needed to be seen. The GP continued to be concerned about Martin and discussed the course of action he had taken with another colleague on the **15th March**. The colleague agreed with the course of action that his GP colleague had taken and thought that he could do no more.

6.6.9. Adult Social Care have recorded the conversation with the GP on the 12th March*: "Telephone call received from GP. Concerned that GP had been called out by the police as client found in a poor physical state, surrounded by faeces, concern regarding his condition and that of the home – GP felt client had capacity to decline hospital admission when offered. GP advised there were no concerns regarding mobility and no acute mental health issues".*

Adult Social Care raised a safeguarding concern regarding Martin 'self-neglecting' – and advised the GP of this. It was agreed that no urgent action was required and that although Martin's case would be managed under the local authority's Care Act 2014 s42 duty he would not be seen immediately; the GP was told it may be some days before contact could be made.

The LAS referral had been received on the 12th March and was used to inform this decision.

The Police Merlin report was received the next day, 13th March, but did not lead to a reassessment of risk and a review of the decision made the previous day.

6.6.10 Later on the 12th March another neighbour phoned L&Q, she thought that Martin had been taken to hospital and asked L&Q to come out and clean the area around the door and door handles as there was an awful smell. She also said that Martin's door had been left open, an L&Q property manager attended but found the door to be shut. L&Q also believed that Martin had been taken to hospital at this point.

6.6.11 Martin's mother and sister had feelings of foreboding about him from Tuesday 13th March 2018 onward. Martin's uncle lived in London and tried to see him the same day but got no answer. Neighbours told him that M had been taken to hospital and the police had been there the day before. Martin's mother phoned round hospitals but they had no record of an admission. By Wednesday 14th March his mother and sister had the feeling that Martin was dead. His mother telephoned the police on Wednesday 14th and asked if they could trace her son. The police officer who spoke with her said that "there's nothing wrong with him except he is living in filthy conditions." His sister rang ASC Thursday, 15th March, and was told only that "we are aware" of Martin. There is no record of this conversation or why information about Martin's situation was not shared or if any concerns expressed by his sister led to the review of the decision made on the 12th March. Martin's mother asked her brother to put a note with her contact details in every mail box in the flats asking residents to contact her if they saw him. A resident told his uncle that they thought he had been sectioned so his mother phoned the mental health hospitals, there was still no sign of him. She phoned the police again and this time spoke to a helpful officer. As a result of her call the police went to Martin's flat on the **16th March** and broke in at about 7pm and discovered that Martin had died. There was a delay in obtaining the police doctor who was on another case at the time. Martin was pronounced dead by the police doctor at 12.04 am on the **17th March**.

Later on the evening of the 16th March the upstairs neighbours phoned Martin's mother, they had her contact details from the note left in the mail boxes earlier in the week. A man said that she should contact the police as Martin was "very ill", a female voice behind him said "he's dead." In this way she learned that her son was dead. She sat up into the early hours with the curtains open so that she could see the police car coming, she wanted to see the car before the knock on the door so that she might be prepared. No police visited so the next day she rang and spoke to a police woman, giving the case number. The standard

police practice is that such news should be broken to a close relative in person, the officers who attended Martin had sent a request to Hertfordshire Police asking them to inform Martin's mother in person. Hertfordshire Police replied to the request to say that they informed his mother at 10.54 hours on 17th March.

6.7 Analysis of the events of March 2018

6.7.1 Support systems around Martin. Martin's condition and behaviour continued to cause concern to his neighbours who took action to get help for him by calling the police. His neighbours believed he had been taken to hospital and were unaware of his true situation. Martin did not give details of Next of Kin to LAS and so his family were also not aware of his situation. After the 12th March Martin was completely isolated from any informal or formal support system.

6.7.2 Duty of Care. Professionals have a 'duty of care' toward vulnerable individuals which can be summarised as the need to consider their situation and what harm may occur to them as a result of professional action or inaction. All visiting agencies identified that Martin was struggling to meet his own basic needs, he had no food, was drinking water out of a dirty bottle, and potentially had mobility issues. All identified him as being very unwell although they could not know his diagnosis or prognosis as he refused clinical assessment. He had no one who could care for him. He was either unwilling or unable to allow access to his flat.

Our duty of care is underpinned by the Human Rights Act 1998, in terms of absolute human rights Martin's right to life (EHRC article 2) was at risk as he was frail with an undiagnosed illness. Constant diarrhoea would leave him at risk of increased frailty. With no support system around him and queries around his ability to stand and walk it would have been doubtful that he could go out to get food. Martin's 'vital interests,' were at risk, i.e. his life was potentially at risk, and it was not clear how he would support his own vital interests. There is no definition of what 'vital interests' are in the adult safeguarding policy used by Lambeth, but this is an important notion in enabling the identification and responses needed for these situations. Martin's right to freedom from inhuman and degrading treatment (EHRC article 3) also needed to be observed. Absolute human rights must be protected by all public bodies.

The three agencies who attended Martin all sought to fulfil the duty of care they held toward him in the best way they could. The police contacted the ambulance service and the ambulance service contacted Martin's GP practice. The GP practice tried to get help from the mental health trust and ASC.

6.7.3 The Mental Capacity Act, how our understanding of the Act may influence decisions about duty of care and self-determination: The GP and LAS explored whether Martin had the mental capacity to make the decision not to go to hospital. Martin was believed to have capacity to decide by both LAS and the GP after their assessments, therefore decisions could

not be made in his best interests. There are two stages to a Mental Capacity Act assessment:

- Is there an impairment of, or disturbance in the functioning of a person's mind or brain? if so

- Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

Both parts of this test must be applied in making the decision that a person lacks capacity to make a specific decision at that time. The LAS assessment established that Martin could fulfil the second part of the test, he could understand and retain information, i.e. he could repeat the information back to the crew. His ability to use and weigh the information was recorded as present although the crew did feel he was behaving '*inappropriately or bizarrely*' in response to the situation he was in.

The GP undertook a mini mental assessment to check whether Martin had 'an impairment or disturbance of the functioning of the mind or brain', the first part of the test. He did not and went on to demonstrate the elements of the second part of the test in conversation with the GP. The assessments were based on Martin's verbal responses, and not explored further with any test of executive functioning, i.e. 'show me you can get up and walk, don't only tell me'. A demonstration of Martin's inability to walk at this point may not have demonstrated that he lacked capacity, but would have prompted further professional curiosity about his rationale, a 'respectful challenge' of his assertion that he could manage by himself, and a risk assessment regarding his ability to care for his own welfare, consideration of any other way of addressing his health needs or a clearer request for an urgent multi agency response coordinated by the local authority.

The purpose of the Mental Capacity Act 2005 is to give a framework for making decisions in the best interests of those who cannot make decisions for themselves, i.e. to uphold the rights of non-capacitated people. In contemporary practice the provisions of the Act can lead to confusion and lack of confidence when working with people who are assessed as having the mental capacity to make a specific decision. If a person makes a decision which seems inappropriate or bizarre, we must be curious and at times respectfully challenge why they are making this decision. If we can understand the person's circumstances, beliefs, fears or concerns we may then be able to explore options and make plans with them. Similar themes have been noted in a thematic analysis of twenty-seven SARs undertaken in London between April and April 2017 (Braye et al 2017)

'..the majority of the evidence and the widespread nature of lessons learnt about Mental Capacity point to fundamental flaws in how the Mental Capacity Act 2005 is understood and applied in practice' (page 20)

Martin might have had the capacity to make a decision, but his ability to self-care was not explored, and at this time his ability was badly compromised. The condition of the flat may well have not been conducive to a long conversation, and Martin would perhaps be using the evasive strategies he had used so well in the past to avoid a course of action he was ambivalent about, but there were many areas to explore before concluding that Martin could somehow maintain his own life for a while longer. What was Martin feeling and thinking? He may, as the police observed, have '*given up on himself*' and be depressed; he may have felt so ill he did not want to move; he may have felt a profound sense of shame at his situation, prior to his illness he appeared to have taken care of himself and his flat, to be incontinent to the degree that he was must have been horrific to him. An exploration of his thoughts and feelings, coupled with challenges for him to show how he would get to the GP surgery or the shops may have provided some way forward or at least accurate risk information to inform a decision about next steps. Martin did consent to LAS referring him to ASC, it is unknown what Martin was expecting would happen to help him.

6.7.4 Consideration of history of substance misuse: The contemporaneous written accounts given by the agencies involved indicate that there was no evidence that Martin was drinking alcohol at this time. It is very unlikely that Martin was drinking alcohol at this point, he may have had a forced alcohol withdrawal as he became too unwell to buy alcohol or too ill to consume it. Knowing that someone has a long history of substance misuse and that they are severely neglecting, and linking this together with typical behaviours, could point agencies to a conclusion that the person will not engage or follow through with proposed actions. It could lead to value judgements being made about his circumstances. The difference at this stage was that Martin was physically very ill, his presentation was not of a person abusing substances but someone who is self-neglecting their health needs, physically frail and in crisis.

Primary care colleagues have reflected that older people with more 'red flags' may get a faster clinical multi agency response. A younger person with no cognitive issues is a rarer concern and would not trigger a clinical multi agency response. The usual response to younger people is to consider using the mental health pathway including sectioning through the provisions of the Mental Health Act 1983, something that Martin's GP explored with Mental Health Services. It is noted that the GP was told that Martin had '*no diagnosed mental health issues'* and was not known to Mental Health services. This would have been an assumption as Martin had not been seen by primary care services since October 2015, and only briefly by secondary or emergency services. Attendees at the second learning event suggested that consideration could have been given to removing Martin to a place of safety via section 135 of the Mental Health Act. Section 135, the power to remove a person from private premises if there is 'reasonable cause' to suspect they have a mental disorder and are unable to care for himself, and are living alone, can only be enacted under a magistrates warrant which must be applied for by an Approved Mental Health Professional. No referral for an assessment under the Mental Health Act was formally made, and we

cannot be sure that it would have been acted upon given the mental health services assertion that they 'did not know' Martin. If the Mental Health pathway is not appropriate then there is currently no clear pathway as to what to do next.

6.7.5 Decision making: On the 12th March there were three forms of information available to ASC, their own records, the verbal information given by the GP and the LAS referral. ASC records would have indicated Martin's history regarding alcohol use. The information recorded by ASC indicates little exploration or curiosity about Martin's situation, he is recorded as being capacitated and '*choosing*' not to take healthcare advice, he is recorded as having *'no mobility issues.'*

The GP has recorded the outcome of the discussion with ASC and appears to have agreed that there was no urgency to the situation. LAS have also badged Martin as ***'not at immediate risk of significant harm***'. The police MERLIN did not arrive until early the following morning and was not used to review the ASC decision made on the 12TH of March. The referral was rated as 'Green', i.e. needing a multi-agency response but not urgent. PPUs use the London MASH Adult harm rating system, Blue Green Amber Red or BRAG, which does describe the features seen in a range of risk situations. However self-neglect is not included in the BRAG, which is predicated on third party harm. The 'Green' category includes the features '*one off incident with minimal significance to the adult'* and '*No evidence of lasting distress*.' The BRAG cannot describe situations of self-neglect. It was suggested by attendees at the second learning event that the 'Green' rating may have also been influenced by the knowledge that an adult safeguarding concern had already been recorded and ASC were aware. An assumption that risk is reduced by ASC awareness is unhelpful, the information in the MERLIN should have been read thoroughly and used to review risk, the Green rating may have inhibited this action.

There may have been elements in the discussion with the GP and there were elements in the written LAS referral which should have roused ASC's curiosity. LAS noted: Martin lived alone. Martin had several months of untreated diarrhoea which had led to the flat and Martin being covered in faeces; Martin may have been vomiting blood; Martin had not been eating; the flat was cold. March 2018 was a very cold month.

The police MERLIN should have prompted ASC to reconsider the decision of the previous day, it documented that '*The fridge bore no signs of any fresh food. Martin had some water left on the floor but this was in a dirty old bottle. Martin was dirty and in dirty soiled clothing. There were signs of blood or dried vomit around his mouth. It is evident to officers that Martin is very unwell. There may be substance misuse and physical ailments. Martin is in need of support and help. This is something that cannot be left*'.

The GP documented that ASC told him they may not visit for a week, and indeed ASC did not attempt to make contact with Martin until the 20th March, eight days later. The initial Management Report regarding these events concluded:

'*I can find no evidence documented on the Lambeth database that there was consideration of the nature of Martin's self –neglecting, level of urgency, health or clarification with the GP as to how possible medical needs would be followed up. Furthermore, no questions were asked about whether Martin was able to leave his flat or had access to food. A greater level of professional curiosity may have helped to determine what immediate action was required*'.

How could ASC discount information indicating that Martin could potentially not meet his basic needs and had a frailty that could compromise his wellbeing and why was the situation not given a higher indication of urgency by the referring agencies? We must remember that no one thought that Martin was dying, and his ability to get out of bed and get food was not certain. However, without further exploration of the meaning of the situation with the referrers an opportunity to understand Martin's predicament was lost. When a service is very busy it is easy to put people into boxes, for example 'no care and support needs' 'self-neglecting' 'capacitated' 'history of alcohol use and non-engagement' and reach a quick conclusion on next steps. We must mitigate against this tendency, and although decisions may often be made by teams that are busy and sometimes overwhelmed, there are steps we can take to give all agencies the tools to make decisions based on accurate information rather than the assumptions that can creep in to a fast-moving day. Useful questions can be: does the person have a current frailty that challenges their ability to care for themselves? Is the person eating, drinking and warm? If the person appears to have a physical frailty and is not eating, drinking or warm then we should be concerned about their 'vital interests.' These factors are useful in arriving at a determination of risk and urgency of response.

If ASC had decided that more urgent action needed to be taken what response could they make? As Martin's GP has indicated, getting into Martin would have been difficult, and although Martin's neighbour understood he was too frail to get to the door, other agencies do not seem to have acknowledged this as an issue in their discussions with him. It is likely that the response would need to be multi agency with Martin's health as well as personal care needs considered, and support from L&Q utilised. A response from ASC alone was not needed, but coordination of a multi-agency response by ASC was crucial.

6.8 After Martin's death.

L&Q have recorded that the flat was given "extreme cleaning" via "extreme environmental" before the family were able to collect the keys and go into the flat to collect Martin's property. Martin's sister reports that this was not the case, when she visited the flat on **19th March** it was "*in a shocking state with faeces in evidence throughout, dust and mould on kitchen counters. The fridge was full of stagnant water*". L&Q did not in fact raise an order to get Martin's locks changed until the 19th in order to give access to the cleaning contractors and did not raise an order to clean the flat until the **20th March**. The condition of the flat was deeply traumatic for Martin's family. The kitchen had not been used for some time. The best before date on the milk was February 2018. There were some Yazoos in the

bin, perhaps he had been trying to drink milk products to keep his strength up. There was no alcohol in the flat. Heating and lighting were available. The water to the sink had been cut off for unknown reasons but there was water in the rest of the flat. Martin was on DLA benefits and had £3000 in the bank, his rent was fully paid up.

Dealing with the paperwork relating to the end of Martin's tenancy was also traumatic. L&Q do not appear to have an appropriate form to complete when someone has died. A 'notice to quit/cessation of tenancy form' had to be completed which asked why Martin was giving the tenancy up. The electricity company was better equipped, having a department which talked to people who were bereaved and trying to sort out their loved one's affairs

7.Findings and Learning Points

We will consider in turn each of the questions posed in the SAR Terms of Reference below:

7.1. To what extent did agencies consider and make use of Mental Capacity Assessments in this situation and are there lessons to be learnt about how it could have been used more effectively?

7.1.1 The LAS and the GP attending did use elements of the two-stage test to assess Martin's decisional capacity. The GP attending used his knowledge of Martin gleaned from medical records to explore whether the consequences of Martin's addiction had impaired his mind or brain in any way. However, the capacity tests were reliant on Martin's verbal responses, his executive capacity to act on his decision to continue to self-care without support was not tested, and a potential avenue to test his capacity to make decisions about his medical care was therefore overlooked.

Learning Point 1: A mental capacity assessment needs to explore more than what a person says they can do, it must also explore whether the person can put these verbal claims into some sort of meaningful action, and if they cannot whether they are able to use and weigh this information to make decisions about other options.

7.1.2 ASC used the GP reported assessment that Martin 'had capacity' as a significant factor in assessing the risks he faced. The fact of his 'capacity' and the belief, untested, that he was able to walk reduced consideration of the risk to his 'vital interests' and the urgency of the response to this risk.

Learning Point 2: The Mental Capacity Act is clear, a person either has the capacity to make a specific decision or they do not, and if they do not have the capacity then a decision must be made 'in their best interests'. Whether a person is capacitated or not regarding a specific decision should not be the end of the assessment of their rationale, beliefs and physical or emotional state and the impact that these have on their decision making. This is particularly important when a person's vital interests are at stake. The factors that influence decision making in these circumstances must be given as much weight in assessing risk and the urgency of response as the assessment that a person has capacity or not. This is not to

suggest that emergency services should undertake what can be a detailed and lengthy assessment, but that when factors are noted as they were in Martin's case, these must be given weight and conveyed on via referrals to other agencies, and may also influence whether such referrals are made and how they are responded to.

2. *How effectively did agencies communicate with one another and is there evidence of joint decision making and responsibility for the case?*

7.2.1 Substance misuse services did not always communicate reliably regarding Martin's situation, thereby reducing the possibility of respectful challenge to his rationale for being unable to commit to an agreed pathway regarding recovery from his addiction. However, a multi-disciplinary team approach was supported via meetings and informal communication. Better communication may have improved Martin's commitment, but ultimately it was his choice to use the range of opportunities that were available to him at this stage of his life.

Learning Point 3: Multi-disciplinary teams should check that communication systems are fit for purpose, do not rely on informal communication between busy professionals.

7.2.2 Both NHS 111 and the St Georges Emergency department sent notifications to Martin's GP surgery which indicated that Martin's health was declining. A further notification from LAS about an incident in February 2018, around the same time as the NHS 111 report may have drawn further attention to Martin's deterioration. However there appears to be no mechanism whereby GP surgeries can a) use this information or b) respond in a preventative rather than reactive way.

Learning Point 4: GP services operate on the premise of onus on the patient to approach the GP. This is a respectful and proportionate approach for the majority of patients, however for patients whose addictions or other factors have led to a disengagement with services that can help, a more focused approach is needed.

7.2.3 The events of the 12th March required a coordinated response to enable communication between agencies to determine the level of risk and the steps that could be taken. This coordination is undertaken by Lambeth local authority under the duties of the Care Act 2014, as described in the Pan London Adult Safeguarding policy. In the absence of this coordinated approach information could not be explored or examined by all those concerned.
Both emergency services, i.e. police and LAS, did enact their duty of care by referring quickly to a service or professional that could address the situation as it appeared to them on the day. The GP had left Martin's flat before consulting colleagues as to what to do next, closing down options for further access to Martin. The GP was unable to engage colleagues in social care in a full discussion to explore what could happen next. The referrals from LAS and the

police conveyed no urgency about the situation, recording 'no immediate risk of significant harm' (LAS) and a Green "BRAG" rating of the police MERLIN referral, these general indicators appear to have been allowed to obscure the factual information contained within the two referrals.

The risk assessment of Martin's situation remained incomplete and an action plan was not agreed by all parties. The attending GP was left feeling very concerned, but had no agreed interagency plan to support getting further access to Martin. The fact that Martin's vital interests were at risk and that an urgent plan was required to see him and support his needs was missed.

Learning Point(s) 5:

a) Police and LAS referrals do not capture the full range of factors that decision makers in ASC should consider. The LAS observation that Martin was behaving '*inappropriately or bizarrely*' to the situation and was '*overly quiet and withdrawn'* was not recorded on the LAS referral. The BRAG for adults does not consider self-neglect or rate the impact this is having on a person's life which makes accurate decision making difficult. How concerns are communicated, what information is given and how risks from self-neglect are rated needs to be reconsidered by all agencies.
b) Information received in referrals from emergency services or via telephone conversations needs to be triangulated and interrogated to avoid assumptions and 'tick box' thinking. This can be hard if a service is busy. Indicators to pick up risk to vital interests and imminence of risk must be devised to inform decision making.
c) If indicators of imminent risk to vital interests are identified there needs to be a mechanism to support an urgent multi agency conversation with all agencies involved. This must include considering if housing agencies are to be involved, in this case L&Q could potentially offer a 'neutral' person to engage with Martin in planning how he could be supported. Attention is needed to the range of responses that can be given, a 'tool box' for situations where a person refuses to engage with services but their vital interests are at risk.

3. *Are there any lessons that can be learnt out of the history of the case i.e. were there lost opportunities and/or lack of professional curiosity?*

7.3.1 See 7.2.1 and 7.2.2 above. Better communication at an earlier stage of Martin's life may have resulted in a preventative response and supported professional curiosity, but this is not certain given that Martin made his own decisions about how and whether to engage. Potential barriers to his motivation, i.e. the requirement to attend three meetings in a row to access rehabilitation services, have now been removed for others.

ASC did not respond to L&Q's emailed concerns in February 2018, losing an opportunity to work together to explore Martin's situation at that time.
Professional curiosity during the time of Martin's final illness is not evident. Attending services' response to Martin's refusal to be examined, or to be conveyed to hospital, was to assess his capacity to make those decisions. The focus on his decisional mental capacity, rather than his executive capacity, his abilities, rationale, beliefs etc meant that opportunities to explore alternative options were lost. No professional curiosity was exhibited by ASC on receiving written concerns or during subsequent conversations with the GP.

Learning Point 6: An understanding of the interaction between self-neglecting behaviour and risk to the person's vital interest must prompt a deeper level of professional curiosity, we cannot merely be satisfied that we are fulfilling our legal duties as regards the mental capacity act. Local authorities receiving referrals need to ensure that their staff have the time and support to exhibit professional curiosity, and to fully explore referrals where a person is documented as physically unwell as well as self-neglecting. In order to prompt such assessments a checklist will be useful alongside changes to policy and procedure documented in 4 below. Inter-agency communication including responding to referrers needs to be an expectation and built into the decision making workstream.

4. *How confident are mainstream statutory agencies when it comes working with people who have both Substance Misuse and Self-Neglect issues? Is there any evidence to suggest that a perceived lack of confidence impeded any actions which might have been taken to protect Martin.*

7.4.1 Whilst perceptions about Martin's history of alcohol addiction may have led to assumptions about the reasons for his circumstances, the issue of Martin's substance misuse is not relevant to the finding about confidence in working with people who self-neglect.

7.4.2 It is doubtful that when a similar situation occurs in Lambeth a different response will be given. There are no pathways or procedures in place regarding actions to be taken if a capacitated person, particularly a person under 65, refuses necessary care and is in a situation where their vital interests may be at risk. There is no definition of 'vital interests' in the Pan London Adult Safeguarding Policy and Procedures used by Lambeth. We cannot rely on using the Mental Capacity Act or Mental Health Act to help us address these situations. Professional curiosity, the principle of 'beneficence' or kind interest in another's welfare, as well as our duty of care are more useful notions.

Learning Point 7: Policies and procedures regarding actions to be taken to understand and assess risks to a person's vital interests are needed, together with an agreed process to follow if urgent multi agency coordination is indicated. Without an agreed process and

understanding of potential multi – agency actions it is unlikely that a confident response will be made to a situation similar to Martin's in the future.

8. Recommendations to Lambeth Safeguarding Adults Board

The LSAB is recommended:

8.1 To review the local Lambeth guidance on assessments of capacity under the Mental Capacity Act 2005 to ensure that the adult's executive capacity is explored where relevant as well as their decisional capacity. The principle of '*show me as well as tell me'* is useful. (*Learning Point 1*)

8.2 To review Policies and Procedures in order to examine how risk to adults who are self-neglecting is understood and assessed; how concerns are communicated; what information is given; and how risks from self-neglect are rated in any tools currently used by partner agencies and to update policy and procedure to include the learning from this review.

Specifically:

8.2.1 Information to inform risk assessment must consider not only the adults' mental capacity but also factors that indicate the rationale for their decision making, their ability to put their decision into action and their physical, emotional and material circumstances. Any information known about these factors must be added to referral forms held by agencies (*Learning Point 5a).* Any BRAG or similar risk rating system used must include risk ratings for adult self-neglecting behaviour (*Learning Point 5a, 7*).

8.2.2 Risk assessments must consider the adult's 'vital interests' and a definition of what this means in the policies and procedures used will be helpful. This concept is useful across all categories of harm, but for people who self-neglect will help to identify those whose self-neglecting behaviour combined with an acute or pre-existing health condition may place their lives in imminent jeopardy (*Learning Points 2, 6*)

8.2.3 All agencies, in particular ASC/MASH adult safeguarding decision-making teams, must have a set of indicators to identify risk to an adult's vital interests and the possible imminence of harm with which to inform decision making (*Learning Point 5b*).

8.2.4 ASC is the coordinator of adult safeguarding enquiries, if indicators of imminent risk to vital interests are identified there needs to be a mechanism for ASC to use to coordinate an urgent multi agency conversation with all the agencies involved. All agencies must contribute to formulating this process which will include contact details and numbers as well as the possibility of immediate conversation with an ASC coordinator whilst the referring agency is still with the adult at risk. This must also include considering how to involve housing or third sector agencies who may know the adult and can help with problem solving. All agencies are also recommended to contribute to the development of a set of

tools to identify creative multi agency solutions to support adults whose vital interests are at risk which will also include legal literacy around potential use of the available legal frameworks (*Learning Point 5c; 6,7*)

8.2.5 Procedures used by ASC decision makers must include an expectation that referring agencies will be responded to within an agreed timescale (*Learning Point 6*).

8.3 To share the learning and recommendations from this SAR with all London Boroughs who use the Pan London Multi-Agency Adult Safeguarding Policy and Procedures.

9. Recommendations to individual agencies:

9.1 NHS Lambeth Clinical Commissioning Group: The Clinical Commissioning Group is recommended to explore whether there is a group of patients in any surgery who need flagging for follow up on receipt of information from emergency services and departments. Useful questions may be: how do surgeries record this information? Are there circumstances when assertive attempts should be made by surgeries to engage the patient? How should engagement be attempted? Long term plans for primary health services in Lambeth (Primary Care Networks) may promote opportunities to create this preventative response. (*Learning Point 4*)

9.2 Lambeth Adult Social Care; ASC is recommended to review opportunities to promote professional curiosity in qualified and non-qualified decision-making staff. Ensure that staff have reflective supervision opportunities, regular development opportunities, consider if processes support professional curiosity and staff have the time to consider and use a curious and considered approach to decision making. (*Learning Point 6*)

9.3 South London and Maudsley NHS Foundation Trust (SLaM) Addiction Service:
are recommended to check that communication systems about patients are fit for purpose, and not reliant on informal communication between busy professionals (*Learning Point 3*).

9.4 London and Quadrant Housing Trust: Whilst not within the scope of the Review the events after Martin's death do produce learning for the London and Quadrant Housing Trust, it is recommended that the Housing Trust ensure that there are a set of procedures supported by appropriate paperwork available for use when a tenant has died that are clearly understood and used by all staff.

10. Glossary of terms used

AA – Alcoholics Anonymous

ASC – Adult Social Care, a Lambeth Council team

BRAG – Risk ratings, Blue, Red, Amber, Green.

CCA – A Community Care Act assessment – pre the implementation of the Care Act in April 2015

CLAS – disused name for shared care services in Lambeth

DWP – Department of Works and Pensions

ICS – Initial Contact Service, Lambeth Council

LAS – London Ambulance Services NHS Trust

L&Q – London and Quadrant Housing Trust

MDT – Multidisciplinary Team

PPU – Public Protection Unit

SAR – Safeguarding Adult Review (pre-Care Act - SCR, serious case review)

SLaM – South London and Maudsley NHS Foundation Trust

SMT – Substance Misuse team, Lambeth Council

11. References

Braye, S. and Preston-Shoot, M. (2017) Learning from SARs: A Report for the London Safeguarding Adults Board. London: ADASS.

Prochaska J. and DiClemente C. (1982) 'Transtheoretical therapy: toward a more integrative model of change'; in *Psychotherapy*; 19:3; pp. 276–88

Appendix 1 Terms of Reference

Lambeth LSAB Safeguarding Adults Review: SAR F

Terms of Reference

Overarching aim and principles of the SAR

The purpose and underpinning principles of this SAR are set out in section 2.10 of the London Multi-Agency Safeguarding Adults Policy and Procedures. All Lambeth LSAB members and organisations involved in this SAR, and all SAR panel members, agree to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

Legislation
Section 44 of the Care Act 2014 places a statutory requirement on Lambeth LSAB to commission and learn from SARs in specific circumstances, as laid out below, and confers on Lambeth LSAB the power to commission a SAR into any other case:

'A review of a 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) if –

a) *there is reasonable cause for concern about how the SA(P)B, members of it or other persons with relevant functions worked together to safeguard the adult, and*
b) *the adult had died, and the SA(P)B knows or suspects that the death resulted from abuse or neglect…, or*
c) *the adult is still alive, and the SA (P)B knows or suspects that the adult has experienced serious abuse or neglect.*

…Each member of the SA (P) B must co-operate in and contribute to the carrying out of a review under this section with a view to –

a) *identifying the lessons to be learnt from the adult's case, and*
b) *applying those lessons to future cases.*

Governance and accountability
This SAR will be conducted in accordance with requirements set out in:

- Care Act 2014 and statutory guidance (DH 2014);
- Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015);
- London Multi-Agency Safeguarding Adults Policy and Procedures (London ADASS 2015); and
- Lambeth LSAB SAR sub-group Policy and Procedure (2017)

As the accountable body responsible for its commissioning, Lambeth LSAB will receive updates on progress of this SAR at Board meetings or via offline written briefings as required.

SAR subject
The summary of details of the subjects of this SAR are:

Name	DOB	DOD	Age	Ethnicity	Known and previous addresses
Martin (adult at risk)	21.01.1967	16.03.18	51 years old	White British	

Brief summary of concerns that triggered this SAR:

Martin passed away, in his property, on 16th March 2018.

He had been seen in his property on the 12th of March by 3 different agencies, Police, Ambulance service, GP and telephone contact made to Lambeth Adult Social Care on the same day. It is noted in an email from his sister that following visits from the three agencies that her brother was left in squalid conditions, physically frail with no adequate support.

SAR methodology:

A 'Significant Incident Learning Process' (option C) has been selected as the methodology for conducting this SAR. This methodology was selected because there was no individual source of risk but several statutory agencies who came in contact with Martin. Details of the methodology can be found in the SAR sub-group policy and procedure on page 14. In brief, the methodology involves:

- Collation of a timeline of events
- Sharing reports with the agencies involved
- Analysis and identification of themes by the group of frontline practitioners involved in the case and their managers plus Report Authors via a Learning Event
- Development of an overview report by the lead reviewer
- Review of the Report by the same group of practitioners and managers via a Recall day event.

Specific areas of enquiry

The SAR panel (and by extension all contributors) will consider and reflect on the following:

5. To what extent did agencies consider and make use of Mental Capacity Assessments in this situation and are there lessons to be learnt about how it could have been used more effectively?
6. How effective did agencies communicate with one another and is there evidence of joint decision making and responsibility for the case?
7. Are there any lessons that can be learnt out of the history of the case i.e. were there lost opportunities and/or lack of professional curiosity?
8. How confident are mainstream statutory agencies when it comes working with people who have both Substance Misuse and Self-Neglect issues? Is there any evidence to suggest that a perceived lack of confidence impeded any actions which might have been taken to protect Martin.

The SAR should cover the time period 01/02/2015 to 16/03/2018

Timescales for completion
This SAR will commence on **03/09/2018** and should be completed within six months of this date.

SAR report and publication
Ms Kate Spreadbury has been appointed as the independent lead reviewer to author the SAR report, the content of which is to be in line with section 11 of Lambeth LSAB SAR Policy and Procedure and the London Multi-Agency Safeguarding Adults Policy and Procedures. It must contain the transparency of analysis necessary for others to scrutinise the findings.

It is expected that an anonymised version of full SAR report or the executive summary will be published on Lambeth Safeguarding Adults Board Website unless there are exceptional circumstances meaning this would not be appropriate. On completion of the report, the SAR panel will recommend to Lambeth SAB how to publish the report, setting out clear reasons for the recommendation.

Involving and supporting the adult and family/ friends/ carers
The review will seek to involve the adult's family in this SAR. The family have stated following the Management Investigation that they are happy for there to be an independent review.

Involving and supporting key staff and volunteers
The review will seek to hear the perspectives of all key staff and volunteers.

The SAR panel member from each agency is responsible for identifying and notifying relevant staff and volunteers about this SAR and giving them the opportunity to share their views on the case.

The SAR panel member from each agency is responsible for ensuring relevant staff and volunteers are provided with a safe environment to discuss their feelings and offered emotional support where needed, including counselling or other therapeutic support.

Disclosure and confidentiality:
Confidentiality should be maintained by all LSAB members and organisations involved in this SAR, in line with the confidentiality statement that forms part of these terms of reference.

However, the achievement of confidentiality must be balanced against the need for transparency and sharing of information in order for an effective SAR to be completed in the public interest, in line with Section 44 of the Care Act 2014, section 2.10 of the London Multi-Agency Safeguarding Adults Policy and Procedures.

All LSAB members and organisations involved in this SAR commit to co-operate in and contribute to this SAR, including sharing relevant information to support joint learning. Where it is suspected that critical information is not forthcoming, Lambeth SAB may use its powers under Section 45 of the Care Act to obtain the relevant information. The Chair of Lambeth SAB and/or the SAR chair may wish to review an organisation's case records and internal reports personally, request additional records and relevant policies/ guidance, or meet with review participants.

The SAR lead reviewer must consider with the family whether they would prefer anonymity for their relative within the SAR report and how they will be referred to.

Communications and media strategy:
Communications advice will be provided to the Board in respect of a SAR and where appropriate the communications approach would be managed by Lambeth Council communications department. All media queries will be referred to the Chair of The Board.

Legal advice:
Legal advice for the Board in respect of a SAR will be sought as required and if appropriate from the Lambeth Council legal department to ensure the SAR process and final report complies with legal requirements and safeguards all parties.

Liaison with the police, criminal justice system and coroner:
There are no police or coroner's investigations ongoing linked to this case:

Links to parallel reviews
The SAR panel has identified that this review links to no other ongoing statutory reviews:

The SAR panel shall keep under review any links to other reviews of practice, such as domestic homicide reviews, serious incident reviews, children's Serious Case Reviews or a SAR being conducted by another LSAB.

Funding and resourcing
Funding of this SAR, arranged by the Board, will be sourced from the agencies which are involved.

Review of Terms of Reference
In the light of information that becomes apparent, these Terms of Reference will be subject to review. Amendments to the terms of reference may be proposed as the SAR progresses but must be approved by the Chair of Lambeth LSAB.