Local Learning Review Alex SMITH

Date of Completion: 28th November 2019

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1. Purpose of the review

This review is designed to learn from the below case, the following principles were be applied:

- A culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of adults.
- We aim to identify opportunities to draw on what worked well and promote good practice and what could have gone better and learn from them.
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time than using hindsight;
- Makes use of any relevant research and case evidence to inform the findings.

2. Methodology of the review

This review will be conducted using a 'signs of safety' learning model and will ask the following questions:-

- What went well?
- What were we worried about?
- What is the learning for future cases**? (Recommendations)**

3. The review team.

Consisted of: -

A. Rick Proctor	Independent Chair Hull Safefuarding Adults Partnership Board (HSAPB) - Facilitator
B. Mark Kelk	HSAPB Manager
C. Wendy Proctor	Humber Teaching NHS Foundation Trust
D. Gemma Cockerham	Renew
E. Sophie Lee	Renew

F. Rachel Hudson	Renew
G. Kerry Shaw	Renew
H. Liz Jamil	Neighbourhoods & Housing Hull City Council
I. Emma Stevens	NHS Hull Clinical Commissioning Group
J. Mags Shakesby	City Health Care Partnership
K. Graeme Irwing	Riverside
L. Marie Mallinson	Riverside
M. Amy Bowman	MEAM (HCC)
N. Michelle Smith	HCC Rough Sleeper Co-Ordinator
O. Kate Munson	National Probation Service
P. Carolyn Taylor	HCC Adults Safeguarding

Case Summary:

Alex SMITH bn 26th November 1981, at the time of his death was resident at Riverside, 55 Great Union Street, Hull. Her Majestys Coroner, recorded a verdict of amphetamine overdose as cause of death.

Alex is described by everyone who knew and worked with him, as a pleasant, intelligent and likeable man. It is known that he attended a Private School, his mother died when he was quite young and his father had a libral view of drug use, telling Alex that he could try anything as long as he didn't become addicted.

Alex was well know to many services, who supported him through his multiple and complex needs. Alex was in poor health, he had contracted hepatitis C, was prone to severe chest infections and had been diagnosed with endocarditis. He had a phobia of needles and would often decline medical treatment.

Alex had initially started to experiment with drug use around the age of 14. During the period from 2011 – 2018 this had become daily use. Alex had and was taking at various stages, opiates, cocaine, amphetamine and had been proscribed methadone. Despite his phobia of needles it is known that he was an intravenous user. Alex would speak openly about this and his needle sharing which knowing the risks, he stated would continue to do, he also knew that he could only access treatment for his Hep C once, this may have influenced his decision not to seek medical attention on a number of occasions together with his belief that giving a blood sample would be difficult and result in a longer than average time in hospital.

Due to the way Alex presented it was believed that he had capacity to choose. Several professionals described conversations with Alex, some quite in depth where he would clearly state that he knew the risks he was taking and understood that if his lifestyle did not change that this would ultimately lead to his death. It is however recognised that due to the belief capacity was not an issue, no formal assessment was considered or safeguarding concern referral made.

Alex spoke really highly of the services supporting him. He valued being able to drop into the Quays, attended the breakfast club provided by Renew and engaged well with the MEAM co-ordinators.

Many efforts were made to provide Alex with his own accommodation, but due to the location not being near to the library, shops and places Alex knew intimately, he did not take up the offer. Alex had a very close relationship with another rough sleeper, Craig, described as being like brothers. It was evident that when Craig was admitted to hospital, Alex without that support around him would, despite accommodation being available choose to sleep rough.

In the months leading upto his death Alex was back in contact with his father, having been estranged for a number of years. It was noted that in the days priorto his death, his health was very poor and given the verdict from the Coroner it is felt by many professionals that his poor health contributed to his tolerances being potentially low.

What worked Well;

It is clear throughout the review that Alex was at the heart of all decisions made by those supporting him. Practitioners, both statutory. Non statutory and third sector showed personal knowledge, a genuine interest in Alex's welfare, care and support needs and tried a number of ways to engage to change the way he lived in order to minimise the risks to him.

Multi-agency work is evident. There is evidence of practitioner meetings and discussions in relation to how best to support Alex.

The adoption by Hull City Council of the Making Every Adult Matter (MEAM) framework is seen as best practice. Altough relatively new, practitioners report a substantial change for the better in the ability to access services and support.

A newly introduced Hull Assessment Hub,(HAH) within the Crossings, has been developed via the Rapid Rehousing Pathway funding adopting the principles and practices of 'No Second Night Out': Providing somewhere safe to stay 24/7 for rough sleepers (up to eight at any one time) identified and referred by Hull's existing outreach team for up to 72 hours allowing for a holistic assessment to be undertaken (taking into account housing, primary/physical health, mental health, substance misuse needs, etc) in order to inform a realistic offer of move-on housing and support.

The service user's housing, health and wellbeing aspirations are held at the heart of the entire assessment process.
All of this results in a comprehensive understanding of the individual service user's needs which informs a credible and sustainable housing, support and treatment offer.

Alex had a history of acquisitive crime, but it is well documented that his offending reduced once he received support. The last instances of Alex committing crime were shoplifting in order to feed himself. Alex engaged with his offender manager, rarely not attending appointments.

Staff welfare for practitioners was also shown to be considered with evidence of both Clinical Supervision and Reflective Practice.

What could have been done better;

Whilst it was believed that Alex had capacity and therefore choice in his decision making. It is felt that a greater understanding and application of the Mental Capacity Act in relation to high functioning individuals with complex needs is required. This can be evidenced in Alex and his phobia for needles potentially being a temporary impairment of the brain elading to his refusal to seek medical support. Record keeping of decisions was also highlighted as an area for improvement, accepting that there is no standardised framework for recording but recognising that decisions need to be written down in order that they may be refered too in an subsequent enquiry.

During the review a lack of clarity of process, in relation to where professionals access support through existing groups e.g. Vulnerable Adult Risk Management (VARM), Making Every Adult Matter (MEAM), was seen as a concern. It was recognised that whilst the work done within these groups was clear to those involved, a wider understanding by practitioners of the terms of reference and pathways in to the groups would be helpful.

Whilst most of the review team present were confident of when to make a Safeguarding concern submission, the issue and thresholds and appropriateness of the referral amongst staff it was felt was not as well understood.

Reviewers were asked about the knowledge of the Local Operating Guidance (LOG). Some present knew of it's existence and referred to it infrequently, others were not aware of the guidance at all. It is recognised that the LOG is in need of review and update.

Recommendations;

- Develop and publish Practice guidance & toolkits in relation to adults at risk who self neglect. Hull Teaching NHS Foundation Trust have recently shared their guidance in relation to self neglect covering not only the legislative tools available but also the phycological aspects why people self neglect. Recommendation to adopt the document. Appendix 1
- HSAPB to assure itself how Mental Capacity Act 2005 is being applied across the partnership (quality assurance process).
- Map pathways which will inform a Vulnerable Adult Risk Management process, subsequently establish the VARM and promote it's use.
- HSAPB to assure itself that agencies ensure health and wellbeing framework is in place for all staff.
- HSAPB to review update and promote use of Local Operating Guidance
- Ensure GP presence at professional meetings when appropriate (assurance to HSAPB from CCG)
- HSAPB to assure itself through the MEAM Strategic Board of continued funding for Hull Assessment Hub, currently set to end March 2021.
- HSAPB to research drug deaths within the city, to establish the extent and if this is perceived or actual issue.

Appendix 1

HFT Self Neglect
Neglect and Hoardi