Safeguarding Adult Review - Jack

Independent Reviewer and Author: Mike Ward

Presented to TSAB on 12 June 2024

Contents

1. Introduction

1.1 Jack was a 20 year old White British male who died alone in a hotel room in January 2023. He was found knelt on the floor at the side of the bed with drugs paraphernalia present. No third party involvement was suspected. He had been placed in the hotel under the severe weather protocol having been no fixed abode. He was known to both Stockton-on-Tees and Middlesbrough Council's Safeguarding Teams. There were concerns regarding self-neglect due to mismanagement of his diabetes, substance use disorders and homelessness. He died from diabetic ketoacidosis (DKA).

1.2 A Section 44 referral for a Safeguarding Adult Review (SAR) was submitted to Teeswide Safeguarding Adult Board (TSAB) by a Safeguarding Officer at Middlesbrough Council in February 2023. The SAR Referral Panel agreed that the case highlighted a number of areas of potential learning, and decided that that a review should be undertaken. This SAR primarily considers a period from September 2022 until Jack's death in January 2023.

1.3 The Independent SAB chair wrote in the SAR recommendation document that: *Jack was an adult at the time of his death, however the fact that he was only twenty years old, in my view, not only adds to the tragedy…but also should provide an opportunity for very careful thought about how agencies work with and provide support to people who are at the very beginning of their adult life.* Jack had previously been identified as a Child In Need and TSAB wanted to unpick how vulnerable children are supported as they transition into adulthood.

1.4 The case also had similar themes to a previous local SAR (Josh) and TSAB wanted to understand whether system barriers and challenges remained from Josh's case.

2. Purpose of the Safeguarding Adults Review

2.1 The purpose of SARs is to gain, as far as possible, a common understanding of the circumstances surrounding the death of an individual and to identify if partner agencies, individually and collectively, could have worked more effectively. The purpose of a SAR is not to re-investigate or to apportion blame, undertake human resources duties or establish how someone died. Its purpose is:

- To establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults.
- To review the effectiveness of procedures both multi-agency and those of individual agencies.

- To inform and improve local inter-agency practice.
- To improve practice by acting on learning.
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.2 There is a strong focus on understanding issues that informed agency or professional actions and what, if anything, prevented them from being able to properly help and protect Jack from harm.

3. Independent Reviewer and Author

3.1 Mike Ward was commissioned to write the overview report. He has been the author of more than twenty SARs as well as drug and alcohol death reviews and a member of a mental health homicide inquiry team. He worked in Adult Social Care for many years but in the last decade has worked mainly on developing responses to change resistant dependent drinkers.

4. Methodology

4.1 A multi-agency panel of the TSAB was set up to oversee the SAR and commissioned the author to complete the review. Agencies were asked to provide initial chronologies of their interaction with Jack during the review period in order to build a greater understanding of the circumstances surrounding the case. In addition to this, each agency was asked to provide a brief summary of any historical and relevant information to be considered by the SAR Sub-Group. Findings from the local Drug Related Death Review Panel were also included.

4.2 The following agencies were consulted:

- Middlesbrough Council (including Adult Social Care, Housing, Drug and Alcohol Team and Children Services)
- Integrated Care Board – Westbourne Medical Centre
- North East Ambulance Service (NEAS)
- North Tees and Hartlepool Hospitals NHS Foundation Trust (NTHFT)
- Cleveland Police
- Stockton-on-Tees Borough Council (SBC) including the Emergency Duty Team
- Tees Esk & Wear Valleys NHS Foundation Trust (TEWV)
- South Tees Hospitals NHS Foundation Trust (STHFT) including the Diabetic Specialist Nursing Team
- New Walk Stockton
- Teak Street Middlesbrough

4.3 Key lines of enquiry were developed (see appendix 1) and subsequently, each agency was asked to provide Individual Management Reviews which offered more detail and analysis on their involvement with Jack. Further information was sought from the involved agencies via a Practitioners' Workshop in March 2024. Some of the information provided included information from outside the SAR's time period enabling a fuller picture of Jack to be developed.

4.4 All of the material was analysed by the author and an initial draft of this report was produced and went to the Review Panel in May 2024. Further changes were made over the next two months, and a final draft was completed in June 2024.

5. Family Contact

5.1 An important element of any SAR process is contact with family. Both Jack's mother and his sister were keen to be involved in the process and the author met with them on three occasions. This report is greatly improved as a result of their insights and contributions. The author is especially grateful to a Young People's Drug and Alcohol Worker who facilitated this contact and supported the family.

6. Parallel Processes

6.1 There were no Police inquiries that coincided with this review; however, the Coronial process was completed during the review and it was determined that the death was due to natural causes.

7. Language

7.1 In talking about individuals like Jack, it is important to avoid language that is victim blaming. However, it is also necessary to use language which is precisely descriptive. In this report terminology around engagement has been debated and, therefore, requires comment.

7.2 The term "difficult to engage clients" is problematic and blaming. It has been replaced with "people that services find difficult to engage". This maintains the emphasis on engagement as a theme without blaming the person by indicating that it is "services that find him hard to engage" rather than that "he is hard to engage". The report author views engagement as a separate process, a necessary pre-condition for providing support or care, and believes that service providers need to have a specific focus on building engagement skills. This precise language is, therefore, felt to be important.

7.3 Middlesbrough Council, however, expressed a preference for "services that people find difficult to engage with". They felt that this better emphasised that the services pose the challenge rather than the individual. The author felt that the language in 7.2 more accurately reflected the real world situation. However, it was agreed to highlight this debate and acknowledge that issues around appropriate language remain unresolved and that this is something TSAB needs to work on. The ongoing debate around terminology reflects the complexity of getting it right for this client group. It also demonstrates how far services have come in being mindful of victim blaming language and being trauma informed.

8. Background and Personal Information

8.1 Jack was born in 2002 and was diagnosed with Type 1 Diabetes at the age of five. Poor management of this condition was a theme throughout his life; it led to Hospital admissions on average every two months, including intensive care on occasions. These were usually due to *"diabetic keto-acidotic coma as a result of poor compliance with treatment including insulin omission"*. (See Appendix 2 for details about Diabetes, its treatment and risks).

8.2 A failure to thrive and problematic behaviours towards his mother were also evidenced, the latter characterised by sleep problems and oppositional behaviour. His home environment was strained while growing up particularly because his father was a drug user. As a result, Jack was assessed to be a "Child In Need" (he was never in Local Authority care and was not a looked after child). Towards the end of his life the relationship with his mother became very strained and he was no longer able to live at home, leading to periods of unstable housing and homelessness.

8.3 His mother described Jack as a “cheeky northern rogue”. He loved family and friends and was very sociable. He also loved music and computers especially drill music. However, he was depressed by the challenges of managing his diabetes and struggled with this. He was smoking cigarettes by the age of 10 or 11 and probably using cannabis from the age of 12 or 13. His mother said that he “loved cannabis”. As a result he became involved with Young People’s Drug and Alcohol Services and did well with them.

8.4 He left school at 16 and went into vocational training and took a bricklaying course and then a forklift truck course because he was planning to work for Amazon. He was described as doing very well during this period. However, Covid significantly impacted this and his training fell apart. In the last year or eighteen months of his life, he began using crack/cocaine and became involved with local dealers who used him to carry drugs. This led to more social instability and to his being the victim of violence.

8.5 Jack’s diabetes was initially managed by the STHFT Paediatric Diabetes Team before transitioning into the Trust’s Diabetes Specialist Nursing Services (DSN). In both childhood and as an adult, Jack was a frequent attender at Hospital, and it was believed that he would sometimes neglect his diabetes to secure ‘accommodation’ in Hospital. Nonetheless, Jack had limited contact with the Ambulance Service during the period under review. There were three callouts all to do with respiratory problems: two on the same day. On two occasions he was taken to Hospital.

8.6 Jack was never involved with secondary care Mental Health Services. He was referred to Psychiatric Liaison due to apparent suicidality: he may have been failing to manage his diabetes as a form of self-harm. However, this was not viewed as needing a long-term intervention. Reports noted that he had been prescribed anti-depressants, but this was not by his GP and does not seem to have been a longstanding pattern. He does not seem to have had a serious mental illness.

8.7 However, in the two years before his death, there are reports that he suffered a brain injury as a result of two or three incidents of serious violence towards him. He is reported to have suffered a traumatic subarachnoid haemorrhage (bleed on the brain) as a result of one of these attacks. His mother described him as becoming “slower, having headaches and a poor memory”. In 2022, there was also a head injury with loss of consciousness following a fall at home as a result of diabetic keto–acidosis (DKA). This potential cognitive impairment had not led to any action by the time of his death.

8.8 As an adult he had occasional contact with the Police, as a result of shoplifting and theft to finance his illicit drug use. However, during the review period he was not arrested; although he had a cannabis warning from November 2022.

8.9 Jack was known to both Middlesbrough and Stockton-on-Tees Councils’ Adult Safeguarding Teams. Concerns were raised regarding self-neglect due to mismanagement of his diabetes, substance use and homelessness.

8.10 Accommodation was a particular problem for Jack in the last two years of his life and at times he was sleeping rough and was described as being *“in and out of temporary accommodation”*. It was difficult to find housing for Jack, many places would not accommodate him due to previous breaches of his tenancy agreements. These housing issues further compounded the risk related to the poor management of diabetes: e.g. limited access to food and cooking facilities, no safe storage for insulin and difficulties in travelling to access insulin or needles and other equipment.

8.11 In July 2022, Jack was referred to New Walk CIC (hostel-based accommodation) by Middlesbrough Council Housing Solutions Team. When he arrived to be booked in, the staff

member on shift disclosed to the Manager that Jack was a close family friend; it was decided that accommodating Jack in the Middlesbrough scheme would not be an option due to this conflict of interest. Therefore, it was decided to arrange an internal move to the organisation's Stockton scheme. This led to him moving from one Tees Local Authority area to another. Jack came from Middlesbrough and his family still lived there; as a result he did not want to live in Stockton and would have preferred to stay in Middlesbrough.

8.12 During Jack's stay in the Stockton facility he was reported to have struggled with managing his diabetes, he often ran out of medication, and attended Hospital to access more. He also struggled to keep his room clean. While he denied any form of drug taking to staff, he was seen smoking drugs in front of the property. A Safeguarding Social Worker was involved with Jack whilst he was there and attended the scheme to see him. He frequently requested food bank vouchers and made use of the food donations the facility received. It was during this period that he was assaulted by a drug dealer. Jack said that he was asked to go and get drugs for someone and when he returned the person claimed he had tampered with them, Jack was assaulted and threatened by numerous people. Staff advised Jack to report it to the Police in order to secure a move for his own safety but on that occasion he refused.

8.13 Eventually his placement in Stockton broke down and he returned to Middlesbrough. At points he was again sleeping rough. During this period he was found collapsed on the street in a diabetic coma and as a result re-formed a relationship with a Young Person's Drug and Alcohol Worker who happened to be nearby. This was supportive in the last month of his life. In January 2023, Middlesbrough Housing Solutions placed Jack in emergency hotel accommodation under the Severe Weather Protocol and it is there that he was found dead.

9. Overview

9.1 The essential question for this SAR is whether the circumstances of Jack's life teaches agencies anything about steps which could be taken to prevent similar tragedies? In the Practitioners' Event, there was a view that Jack was a capacitous adult who made choices about drug use and the management of his diabetes that contributed to his death. This, it was argued, limited what services should have done to help him.

9.2 Yet, it was also acknowledged that at the age of 17 years and 11 months, as Jack was transitioning into adult services, no-one would have been surprised to learn that just over two years later he would have died from DKA. His death was very predictable. He had a lifelong history of poorly-managed diabetes and drug use. He had faced adverse childhood experiences such as parental substance use. Perhaps more crucially, he had lost some of the supports that had sustained him when he was a Child In Need.

9.3 This transition into adulthood has often been described as a "cliff edge" for more vulnerable young people. In that two year period Jack also fell victim to exploitation by drug dealers and was abused by them when something went wrong.

9.4 It would be easy to make a broad recommendation that more assertive follow-up of all Children In Need is required as they transition into adulthood. However, the Practitioners' Event highlighted the scale of such an undertaking. They suggested that it would be far too resource intensive and that many young people are able to make robust decisions about their lives.

9.5 The question is, therefore, are there young adults (particularly Children In Need) who, despite the resource challenges and the issues of personal and family responsibility, need

more assertive follow-up and support in early adulthood? If there are, what are the issues that need to be considered in providing that support?

9.6 To answer that question, this report covers the following themes:

- Support during the transition into adulthood
- The response to substance use
- The management of diabetes
- Mental health
- Engagement / assertive outreach
- Housing
- Safeguarding and other Social Care Interventions
- Appropriate use of legislative frameworks, particularly the Mental Capacity Act.
- Cognitive impairment
- Family involvement

9.7 In addition the report will comment on the impact of Covid and Jack's history of smoking.

10. Transition

10.1 Jack had only been in adult services for two years when he died. Prior to that he had had extensive engagement with a range of children and young people's services. He was a Child In Need, he was engaged with Young People's Drug and Alcohol Services and, in particular was engaged with Paediatric Diabetes Nursing Services. All of these inputs ended when Jack reached 18.

10.2 Jack's care provides one model of a very robust transition process – the move from Paediatric to Adult Diabetes Services. STHFT report states that: *As per NICE guidelines*[1] *… from the age of 15 transition patients are identified and introduced to staff from the adult service alongside nurses from paediatric services. Joint appointments can be at a location appropriate to the individual – school or college, hospital, home, and can have family included at the preference of the young person. These appointments are quarterly as a minimum but can be up to weekly in some cases. This joint working can be maintained until the individual is aged 19 in order to provide a more intensive support; the caseload within the paediatric diabetic service is significantly lower than the adult service therefore more time can be offered to each individual.*

10.3 At the Practitioners' event, the Paediatric Nurses described a process that started even earlier, with some work beginning when children moved to senior school.

10.4 The Drug and Alcohol Services also commented that they begin to: *transition young people into adult treatment (if needed) at 17 years and 8 months. This allows for a period of 'handholding' and helps to address differences in YP and Adult service delivery.*

10.5 On the other hand, Children's Care involvement with Jack ended when he was 18 years old and consequently they were not involved in multi-agency working with Jack as a young adult. Therefore, Jack's situation raises questions about the adequacy of these pathways. For example:

- Adult Social Care state: *"This case has highlighted that there are still gaps in the transitions pathway…Jack was known to children's services as a Child In Need…there is potentially a missed opportunity for a referral into Adult Services at age 17 for Jack.*

[1] NG18 - Diabetes (type 1 and type 2) in children and young people: diagnosis and management - 2023

- Drug and Alcohol Services identify that: "*Challenges occur when adult services are office based. It is felt that outreach work significantly improves engagement and positive outcomes. In addition, it is felt that once young adults turn 18, they often 'opt out' of support services as some feel that they have been 'done to.'…once young adults have a choice, they will sometimes withdraw consent.*"
- Children's Services comment that: *There is a lack of clarity regarding communication between Children's and Adult Services where Children's Services remain involved with the young adult's family in relation to younger children.*
- STHFT acknowledge that: *the most significant challenge centred around Jack's responsibility to manage his care independently once an adult,* and that this would be difficult *due to his unstable lifestyle, environmental circumstances, difficulties in regulating himself and his emotions, his unmet accommodation needs and fluctuating drug / alcohol use.*
- Children's Services also identify more practical problems: *"One of the key issues impacting on effective transitions is staffing capacity across adult and children social care. The turnover of staff in Children's Care has impacted on our ability to embed referral process, and there are at times late presentation of cases to adult social care. Within adult social care vacancies and sickness absence also impacts on our ability to become involved in cases at an earlier stage to co-work with children's social workers."*

10.6 Given resource limitations it may be hard to target all Children In Need who turn 18. Indeed, not all will require that level of support. However, Jack does highlight that some young adults may benefit from a continuation of the more intensive support that they received in childhood. These will be those at the greatest risk. The question is how far does that definition of "at the greatest risk" extend?

10.7 Strictly within the context of this report, Jack suggests that young people with poor management of their diabetes and, in particular, poor management plus substance use are particularly at risk and may require more intensive follow up. The Ambulance Service commented that *"There have been several statutory reviews where diabetes has been highlighted as an area of concern linked to self-neglect."* The Josh SAR also highlighted someone with poorly managed diabetes. Diabetes specialists at the Practitioners' Event indicated that there were other individuals like Jack.

10.8 Stretching the risk category further, the report suggests that young adults using substances are at particular risk of exploitation by dealers and could be another group for more intensive follow-up. Those with housing problems are another group, particularly if combined with drug use or poorly managed diabetes.

10.9 How far this goes beyond these groups is essentially a "political" decision. To what extent should resources be devoted to any particular set of needs? However, it can be argued on the basis of this report that young people with adverse childhood experiences and substance use, or those with unstable housing constitute further groups that need to be followed up.

10.10 The need to address this issue has been identified locally. Adult Social Care have developed a Strategic Transitions Forum: *We will use this meeting to work through some of the issues that have been highlighted.* It is recommended that the prioritisation of follow up support for certain groups of young adults is considered in that process and it is also recommended that people in Jack's situation, with poorly managed diabetes should be a priority.

11. Tackling Drug Use Disorders

Generic Identification

11.1 This section primarily focuses on the work of specialist Drug and Alcohol Services. However, it is also important that generic services identify and address substance use. This will ensure that problems are identified and addressed at the earliest point.

11.2 NICE Guidance states that best practice would ensure that a drug and/or alcohol screening tool is routinely being used at assessment by all relevant professionals, whether in Primary Care, Mental Health Services, Adult Social Care, Housing or any other appropriate adult service. NICE recommends the use of the AUDIT tool for alcohol[2] and the Department of Health advocates the use of the Assist-Lite[3] screening tool for drugs, although other tools such as the DUDIT[4], which is used locally, are available. These tools can be used with young people over 16 years of age.

11.3 It is positive that STHFT reported screening and monitoring for drug or alcohol use as part of an assessment at every contact with the service, and that intervention is offered appropriately depending on outcome. STHFT staff also regularly made links and contact with appropriate agencies for drug and alcohol support in the community.

11.4 However, other agencies identified problems in this area. TEWV staff should be using screening tools; however, the tools were not completed during the mental health state examination of Jack. Nonetheless, TEWV practitioners did liaise with Ward staff, appraised clincal notes and sought assurance that appropriate referrals were made to Drug and Alcohol Services.

11.5 NTHFT staff identified Jack's substance use on admission. Cocaine use was identified on his discharge letter but there was no mention of this in his medical records. Cannabis use was identified in the admission records, but not recorded on discharge letter. No referral made to Drug and Alcohol Services.

11.6 Other services do not specify whether they routinely identified substance use and made referrals. At the most generic level, Jack is a reminder of the importance of the need for robust drug and alcohol screening processes. Without such data it will not be possible to build an appropriate response to the individual; but it will also be harder to build a case for a general improvement in the approach to substance use disorders.

Engagement with Young People's Substance Misuse Services

11.7 Jack began using cannabis from the age of 12 or 13. As a result he was well known to the Young People's Drug and Alcohol Services and had numerous episodes of engagement with them. For example, he was with them from September 2018 as a result of his cannabis use. This support continued as part of his Child in Need plan.

11.8 These services were assertive in their approach and sought to maintain engagement with Jack. He seemed to respond well to this approach. He did not give up cannabis use, but the service may well have prevented early escalation into more serious substance use and supported him with the challenges he undoubtedly faced. This period is not the prime focus

[2] Alcohol Use Disorders Identification Test (AUDIT) (auditscreen.org)
[3] ASSIST-Lite screening tool: how to use - GOV.UK (www.gov.uk)
[4] Drug Use Disorders Identification Test (DUDIT) | www.emcdda.europa.eu

of this review, but it does highlight the benefit of an intensive and assertive approach with young people.

Adult Drug and Alcohol Services

11.9 At the point of transition, Jack linked with adult Drug and Alcohol Services. It was reported that he engaged well, reduced substance use and began to explore his housing and work situation. However, Jack stopped engaging during the Covid lockdown and began using cocaine and illicit pregabalin. At this point he also became a target for drug dealers who began exploiting him.

11.10 In September 2022, Jack was seen by the Hospital Drug and Alcohol Liaison team whilst an inpatient. They liaised with the Drug and Alcohol Services in the community on his behalf, for support with cannabis use. However, he does not appear to have pursued this.

11.12 In November 2022, Jack was found collapsed in the street and taken to Hospital. A Young Person's Drug and Alcohol Worker who knew Jack happened to be on the scene, and informed those present that Jack had diabetes and probably did not require naloxone[5]. The worker prepared a bag for Jack, including some clothes, toiletries, and a mobile phone, and took it to the Hospital. Jack was sleeping and was not spoken to directly, but the bag was left for him. It included the telephone number for the worker.

11.13 In early January 2023, the Young Person's Worker received a text from Jack, thanking her for going to the Hospital, and advising that he still had the mobile phone. Jack consented to a referral to the Young People and Family Team. The next day Jack attended an assessment. He reported that he had stopped smoking crack and taking illicit pregabalin but was smoking cannabis. He was allocated to the same worker for ongoing recovery support.

11.14 She had two subsequent face to face appointments with Jack prior to his death on 18th January 2023 and 20th January 2023. On the 18th January, Jack had disclosed that he had been sleeping rough behind Sainsbury's for three days and had not eaten, Jack was given something warm to eat and drink and was supported to contact Housing Solutions. During the later appointment, Jack reported that he had not used cannabis for four days but was going to buy £20 worth. The worker gave harm minimisation advice. During this engagement he was also given basic support with accessing food e.g. access to a foodbank or a £10 Greggs voucher. Through this contact he accessed accommodation in the hotel where he died.

11.15 Although Jack's substance use remained unresolved at the end of his life. The interventions described suggest that again, both as a young person and as an adult, the approach that was most effective with him was assertive outreach. This is a theme that will be returned to in a later section of the report (14).

12. Diabetes

12.1 At the centre of Jack's care is his diabetes. This imposed challenges not often experienced with other homeless, substance using young people. He required:

- regular access to appropriate food when taking his insulin.
- a place to store his insulin.
- a clock or watch to remind him of when to take his drugs.
- access to a pharmacy and to the health services that are supporting him
- a mobile phone to contact health care staff

[5] A drug which brings people out of an opiate overdose

- annual diabetes checks
- retinal screening and diabetic foot checks
- facilities to power devices used to check blood glucose levels.

12.2 In Jack's case there is documented evidence that he struggled to manage his diabetes due to lack of equipment or medication and was often given resources that he needed to manage his diabetes when he was discharged from Hospital. It is believed that Jack would sometimes self-neglect his diabetes in order to secure 'accommodation' in Hospital.

12.3 However, the agency reports clearly indicate that efforts were made to manage Jack's diabetes. There was an awareness that he needed particular support and more specific types of accommodation.

12.4 For example:

- STHFT's DSN team went to considerable lengths to engage Jack. He was provided with food, with money for food and sometimes clothing. They employed an assertive approach and embraced every opportunity to try and promote his self-care and safety.
- Middlesbrough Council highlighted that because insulin controlled diabetes will likely require safe storage of the medication, the person will likely be in priority need of accommodation when being assessed under the homelessness legislation. It also means the Local Authority would be likely to have a duty to provide emergency or temporary accommodation.
- STHFT highlighted a number of steps taken to support Jack in the community: *24th September 2022 he was given a blood glucose monitor; … 12th November when he was discharged home insulin and needles were provided; 10th December 2022 when he was discharged he was given food, drink and insulin supplies.*
- A Housing Provider supported Jack to manage his own medication via signposting and working in partnership with other services and agencies.
- His Social Worker provided food items not requiring fridge storage, which is good practice and there was consideration of the barriers faced by Jack in having access to food whilst in temporary accommodation.

12.5 Nonetheless, there was concern about how this aspect of Jack's care was managed:

- A Housing Provider comments on the challenge of working with someone who would prioritise other choices over his self-care, diet and hygiene.
- STHFT highlights the tension between the principles of Making Safeguarding Personal and someone who is self-neglecting, particularly if that self-neglect is a response to issues such as trauma.
- Moves to different areas can disrupt links to pharmacies where they have been accessing medication or other supplies and impact on their links with specialist diabetes services.
- Adult Social Care in Middlesbrough comments that: *On reflection there is some learning around additional case monitoring and professional curiosity around the service user being able to maintain a good routine as the case was quickly closed to the social worker.*
- The Housing Department comments that improvements must be made to address health related illnesses and substance use. Health professionals and substance misuse teams must work in collaboration.

12.6 The Ambulance Service had no relevant experience with Jack; however, they made some interesting points about diabetes management in their report. They highlight that the *management of self-neglect in relation to substances and diabetes does vary across the region, e.g. some Local Authorities will have professionals information sharing meetings,*

some will request an MDT (Multi-Disciplinary Team meeting), others might be open to safeguarding but…the onus is generally on the Local Authority leading on this. The Ambulance Service perspective was that Section 42 safeguarding responsibilities are too often left to Adult Social Care when they are not best placed to manage self-neglect related to health issues like diabetes.

12.7 Adult Social Care themselves reported that they had raised ongoing concerns in multi-agency forums about the lack of physical health outreach support from Community Nurses for those experiencing homelessness. They are concerned that criteria are applied strictly in terms of whether the individual is physically able to attend a GP surgery and does not take into account risks around neglect which warrant professional oversight.

12.8 On the positive side, it was noted that the STHFT Adult Safeguarding Team meet quarterly with the Trust's DSN team for case reviews with the aim of identifying adults that services find difficult to engage, to explore any additional possible interventions, up to and including a referral to the local authority High Risks Adult Panel (HRAP).

12.9 Diabetes is the crucial factor in Jack's death. Significant efforts were made to support Jack to manage his diabetes; however, his care highlights the need for ongoing training and messaging to highlight that both poorly managed diabetes and some pattens of substance use are a form of self-neglect and that there is a need to raise safeguarding concerns about such individuals.

13. Mental Health – a note

13.1 Jack's mental health was assessed and reviewed at points in both his childhood and adulthood. Generally, this was related to concerns that he was using the poor control of his type 1 diabetes as a means to self-harm. However, this is not a key theme in Jack's care.

13.2 As an adult Jack did not have any treatment episodes with secondary care Mental Health Services. However, he was referred on at least three occasions to Liaison Psychiatry. Their assessment identified that Jack had no secondary mental health community nursing needs and that his low mood could be attributed to social factors around self-care skills, finance, and social support. There was a robust plan clearly evident within clinical care records stating that Jack had agreed to a Social Care needs assessment referral submitted by the Acute Hospital. The DSN planned intensive input into the multi-disciplinary team to reduce the very significant risk of serious diabetic complications.

14. Difficulty of Engagement – the need for a policy

Overview

14.1 The fundamental challenge with Jack was not that he had a drug use disorder or diabetes or that he was homeless. The real challenge was that services found it difficult to engage him into the care he needed for those problems.

14.2 Throughout the notes there are repeated examples of the challenges Jack posed e.g.:

- There are multiple non-attendances at Hospital, diabetes and primary care clinics.
- Jack was contacted by his Medical Practice about his flu vaccine however he did not attend.
- He did not engage with Drug and Alcohol Services at points in his adulthood.

- STHFT comment that ongoing effective management of Jack's self-neglect was a challenge because…overall his engagement with support agencies wasn't good.

14.3 Engagement is the fuel on which any care process runs. Without engagement care cannot progress.

14.4 Jack is not unusual in presenting difficulties of engagement. The Manchester Safeguarding Partnership *Carers Thematic Learning Review 2021* identifies the same issue: *The challenges of supporting adults who do not consent to treatment or support and who are judged to have the capacity to make those decisions in an informed way…* The review goes on to comment on: *a sense that their persistent refusal of offers of care and support were perhaps too readily accepted, perceived and interpreted by practitioners as 'non-compliance' rather than as a form of self-neglect, which was a product of the adults' adverse life experiences, poor quality of life and very challenging day to day living*.

14.5 Another review from Manchester, the *Homelessness Thematic Review,* comments that: *When faced with service refusal, there should be a full exploration of …what might lie behind a person's refusal to engage; loss and trauma often lie behind refusals to engage. Contact should be maintained rather than the case closed, in an effort to build up trust and continuity.*

14.6 Locally, the STHFT IMR commented that: *The principles of making safeguarding within the Care Act (2014) suggest that effective intervention in cases of self-neglect is dependent on the ability to engage and build rapport with the individual...*

A Policy on Engagement

14.7 Virtually every section of this report has highlighted the need for a new approach to engaging individuals. At the organisational level, this flags up the need for a published, multi-agency procedure to guide professionals in dealing with non-engagement. To make that procedure useful it will need to provide guidance on:

- how to judge the level of risk or vulnerability that warrants ongoing, assertive action;
- how to practically intervene with individuals that services find difficult to engage; and
- how to escalate those concerns and where they should be escalated to.

14.8 It will need to cover themes including:

- Multi-agency management
- Assertive outreach
- Guidance on engagement techniques
- The need for a longer term view of the situation.

These four themes are explored in the following sections of the report.

Multi-Agency Management

14.9 The discussion at the Practitioners' Event suggested that Jack's care would have benefited from escalation to a regular multi-agency forum involving Emergency Services, Health, Mental Health, Drug and Alcohol Services, Adult Social Care and Housing Services, among others.[6] Comments in the IMRs and other documents support this:

- Middlesbrough Adult Social Care comment that: *It appears there were missed opportunities to hold an MDT or Safeguarding meeting to pull the agencies together to discuss the ongoing concerns…*

[6] Police and Community Safety could also be regular members of such a group.

- The SAR recommendation itself comments that: *Information sharing and multi-agency communication could have been better and more coordinated.*

- The Acute Hospital held a meeting to arrange Jack's discharge from care and sent a Duty To Refer (for housing) email to the Local Authority. However, the Drug and Alcohol Death Review meeting notes asked whether the Hospital could have included the Housing Team in the meeting to ensure a full multi- agency approach prior to discharge.

- Housing comment that: *Multi-agency working is key when addressing the needs of young adults. Recovery Solutions have developed pathways with agencies such as sexual health, CAMHS (Child Adolescent Mental Health Services) and CSC (Children Social Care).*

- The Ambulance Service comment on the general need to convene an MDT, share information and put a supportive management plan in place.

14.10 Nonetheless, it has to be acknowledged that there was multi-agency working with Jack. Many agencies had involvement with him[7] and there was communication between agencies and referrals were being made to an appropriate agency for support. There were also, at least, two multi agency meetings:

- the DSN team document attendance at an MDT meeting arranged by Stockton safeguarding team on 5th September 2022
- Jack also had a multi-agency frequent attender's plan and a frequent attender's meeting was held in March 2021: before the review time period.

14.11 Nonetheless all the comments on the case suggest that escalation to a specific, ongoing multi-agency group to develop a plan and monitor its outcomes would have been useful. This group could have ensured:

- Information was shared
- Points of disagreement could be debated
- A jointly owned plan was developed
- Agencies were challenged to try different approaches
- Work continued until Jack was able to engage positively with services.

A regular multi-agency framework would also have facilitated agencies identifying any deterioration in his well-being.

14.12 STHFT described the advantages thus: *Multi-agency working encourages closer communication and working relations between various services with which a young adult may be involved. It helps the young adult with care and support needs as it allows different professionals to work together to try and find the most appropriate intervention to meet those needs. It provides regular opportunity for professionals to meet together to maintain an accurate and current picture of the young adult (where they are, who has had contact etc.), and formulate collaborative and robust plans to try to support them.*

14.13 In both the IMRs and the Practitioners' event, there was mention of the monthly High Risk Adults Panel (HRAP) for cases that are high risk and require strategic escalation. This has been designed to replace the 'Team around the Individual'. This has only recently commenced so it is too early to evaluate its effectiveness. It is also not clear that Jack would

[7] Housing Solutions Officers; Recovery Solutions Officers; Access Safeguarding Team and Hospital Team Social workers; Ward staff in James Cook University Hospital; Stockton LA Social Workers; Diabetes Nurses

have been appropriate for this forum, but it remains a possibility that could be considered locally.

14.14 Nonetheless, partners to the Teeswide SAB could benefit from having a standing specialist multi-agency group that focuses on complex individuals, particularly those that services find difficult to engage. This would provide a structured alternative to ad hoc meetings. This approach has worked well with people with alcohol use disorders in other areas e.g. Sandwell, Northumberland.

14.15 NB - In the case of young adults like Jack it will be important to engage Children's Care into this multi-agency working. There was no evidence on the case record of communication with Children's Care from Adult Services when Jack became homeless despite Children's Care's continued involvement with the family at that time.

Assertive Outreach

14.16 The multi-agency approach would be more powerful if it was supported by assertive outreach. This has been commented on already in other sections e.g. 11. The same comments apply in this section. It would be useful to have the commissioned capacity to provide this approach not just to people with drug and alcohol use disorders but to all self-neglecting individuals that services find difficult to engage.

14.17 An assertive outreach approach is built on the recognition that with complex individuals such as Jack, agencies are going to need to sustain the relationship rather than expecting him to be able to do that. This will require an approach that is:

- Assertive – using home visits
- Focused on building a relationship
- Flexible – person focused – looking at what the person wants
- Holistic – looking at the whole person
- Coordinated – linking with other agencies
- Persistent and consistent.

This is resource and time intensive but can be justified by the repeated impact that Jack was having on public services and his high level of risk and vulnerability: a level of risk which could well have risen over time.

Understanding Engagement Techniques

14.18 This whole process would also benefit from guidance on what techniques work with people that services find difficult to engage. This is an under-developed field. The SAR author looked for national guidance on this issue as part of the drafting of this report but could not find an overarching guidance document. Reports such as "The Keys to Engagement" (mental health)[8] and "The Blue Light Project" (alcohol misuse)[9] have addressed this issue with specific groups but there is no single guidance document. Whether at a local or a national level, such guidance will be a vital support to those working with vulnerable individuals that they find difficult to engage.

A Long-Term Perspective

[8] https://www.centreformentalhealth.org.uk/sites/default/files/keys_to_engagement.pdf
[9] https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project

14.19 Middlesbrough Adult Social Care comment that Jack's presentation fluctuated. At times he was managing well, seeing to his personal hygiene and meeting his health needs. However, Jack was not able to consistently achieve a good routine and it appears that at times Jack's case was closed following a number of weeks of achieving a good routine where concerns were no longer apparent. This does indicate the importance of a longer term perspective with Jack. Staying with him to support him through what were very predictable periods of further instability.

15. Housing

General

15.1 In the short period of his adult life, Jack became very difficult to house due to his behaviour. He moved between several temporary accommodation provisions. For example, in December 2022 he was evicted from a placement due to property damage. It was commented in the original SAR notification that challenging behaviour remains a barrier when trying to place people who are at high risk.

15.2 A very frequent comment in both the IMRs and the Practitioners' Event was the lack of residential options for vulnerable people:

- A Housing Provider commented that: *there are a limited number of commissioned places in Middlesbrough which deal with vulnerable homeless people*.
- Middlesbrough Adult Social Care noted that: *Being limited in options means that the LA has to consider placements outside of the borough and offers which differ from the standard and preferred offer.*
- Middlesbrough's Housing Department commented that: *There is a shortage of places in Supported Accommodation in Middlesbrough. Supported accommodation can often have people with similar issues, such as drug use, housed together. If a person is evicted, they leave instantly, with no support package or 'back up' plan. Our service developed 'survival packs' with emergency food, a blanket and a list of support services and where to access free food.*

15.3 It is likely that these messages would be heard in most parts of the country. This SAR can do no more than flag up the problem of the under-funding of the housing sector that these comments highlight.

15.4 On the positive side, Middlesbrough Council's Housing Team's IMR commented that: *The Local Authority is carrying out ongoing work to address this and has commissioned a new Framework of providers which will be in effect from Spring 2024. Under the new framework, it is hoped that more self-contained accommodation will be offered by providers, and that new providers coming on board will allow the LA to place those who cannot be placed with existing providers due to conduct or issues in previous placements.*

15.5 However, Jack's case does highlight some specific issues:

- Discharge from Hospital to homelessness
- Accommodation for people with diabetes
- Accommodation for people with challenging presentations
- The problem of moving authority.

Hospital Discharges

15.6 The Homelessness Reduction Act 2017 introduced a duty on specified public authorities to refer service users who they think may be homeless or threatened with homelessness to Local Authority Housing Teams**.** This specifically includes Hospitals.

Therefore, in accordance with the Department of Health & Social Care Guidance Discharging people at risk of or experiencing homelessness, Hospital staff must identify homeless patients on admission and have a 'duty to refer' them to a Local Housing Authority.

15.7 The agency reports provided information on the use of these provisions with both Jack specifically and more generally.

15.8 With Jack, a duty to refer was completed to Middlesbrough Council in March 2022 by the DSN team when Jack reported that he had been sleeping on the streets for a couple of nights. A further duty to refer was submitted by Hospital staff on 26th November 2022 when Jack again reported he was homeless. More generally, during further admissions in September 2022, the DSN team arranged various forms of support when he was discharged.

15.9 However, on occasions his discharge from Hospital was less satisfactory. The Practitioners' Event suggested that there were still occasions where people were being discharged to homelessness. More specifically, in November 2022 and January 2023, the Young Person's Recovery Worker who had visited Jack in Hospital and brought him essential supplies was not informed when Jack was discharged from Hospital, even though this had been requested. On the second of these occasions Jack ended up sleeping rough and had not eaten, suggesting that Jack was discharged from Hospital without accommodation.

15.10 More generally, the IMRs comment on the adequacy of this process:

- A Housing Provider commented that: *Without specific reference to Jack we have found that the hospital discharges of homeless people occurs in varying degrees of effectiveness.*
- Middlesbrough Adult Social Care state that: *There are occasions when a patient can be in hospital for less than 24 hours which means the duty to refer isn't completed and the Housing Solutions Team will receive a phone call when a patient is being discharged. An assessment can be arranged over the phone in these cases.*
- STHFT note that: *When a patient is homeless discharge from hospital is always contentious in terms of safeguarding; how can it be a safe discharge if the individual has nowhere to go, but equally it is not appropriate to delay discharge from hospital until a suitable housing placement can be identified.*

15.11 It should be noted that this may not be a simple case of staff failing to pursue the Duty to Refer. On a couple of occasions Jack essentially self-discharged making any follow up more complicated. On another occasion, it is stated that staff were unaware that Jack was homeless because he did not tell them.

15.12 Positive action is being taken to improve this pathway. For example, TEWV has a working group with representation from both clinical services and Local Authority Social Care leads to develop a 'Discharge homeless guidance' for TEWV practitioners. In STHFT, the Transfer of Care Hub within the Acute Hospital will act as a point of contact to secure temporary accommodation. The Alcohol Care Team at the Hospital also now has access to a data system that creates an opportunity for effective information sharing, and understanding of what professionals are involved and should be included in discharge discussions.

15.13 Creating safe discharges from Hospital is an ongoing problem. Work is being undertaken to address this issue but the SAB could usefully monitor progress in this area through regular reporting from partner agencies.

Accommodation for People with Diabetes

15.14 Section 12 considered the management of diabetes both generally and specifically in relation to Jack. It highlighted specific requirements to support him with accessing food, health care and storing drugs and needles. These requirements dictate the type of accommodation that will be appropriate. This section will not repeat the earlier list of needs. It will simply reassert the importance of accessing those facilities when accommodating Jack.

Accommodation for People with Challenging Presentations

15.15 Irrespective of the impact of his diabetes, Jack was very difficult to place. He was placed in temporary accommodation for the first time in early June 2021 and was asked to leave three month later due to reports by neighbours that he was “bringing trouble to the door”, including cannabis use. For the next four months Jack may have been staying with his mother but this broke down.

15.16 In January 2022, Jack moved into a commissioned supported accommodation service for single people aged 16-60. He was there for a little over two months and again problems occurred. He was stealing from others (including his father who was also resident there). He was then placed in a commissioned Young Persons Supported Accommodation Scheme. However, after two months, Jack wanted to secure alternative accommodation due to “grasses” living there. He was then evicted for theft of a bike. In December 2022, he was evicted from another property due to damage.

15.17 At this time Housing Solutions, said that he could not be placed due to his past behaviours during other periods of temporary accommodation. Middlesbrough Council acknowledge in their IMR that this highlights a lack of providers of accommodation for people with what are deemed to be inappropriate or risky behaviours. This is particularly true when looking for private sector placements which was the only option now open to Jack. They did note that if Jack did well in his recovery it might be possible to reconsider his options.

15.18 The availability of accommodation and his behaviour are not the only problems Jack faced in securing accommodation. Jack didn’t have his own bank account, therefore, benefits had to be paid into his mother’s account. He was often without any method of communication, which obviously made contacting him difficult to arrange appointments.

15.19 Ultimately, as a result of the Severe Weather Protocol, Jack was able to be temporarily housed in a hotel where he was visited by the Young Person’s Drug and Alcohol Team. It was in this property that he subsequently died.

15.20 Nonetheless, this does highlight the need for work to develop a range of accommodation options for people who are challenging to accommodate. This will require multi-agency and possibly cross-border working.

Cross Boundary Care

15.21 Jack saw Middlesbrough as his home. However, when Jack was about to be placed in a local residential facility, it was decided that because of a prior relationship with a member of staff, Jack needed to be relocated to the equivalent facility in Stockton. This raises questions about cross-boundary moves.

15.22 For some agencies, such as the Ambulance Service or TEWV, the move made no difference. However, Middlesbrough's Housing Department reported that: *in my experience, clients (post 18) are completely 'lost' if they cross LA boundaries.*

15.23 By moving areas, Jack also moved between the catchment areas of two Acute Trusts. STHFT commented that: *Managing individuals who regularly transition between different local authorities proves to be a significant challenge in terms of providing the consistent and stable support that is necessary when trying to safeguard them. Different areas have different agencies and different systems / processes which obviously can complicate management of cases, therefore information sharing is not as thorough or as comprehensive.*

15.24 A complication specific to Jack's healthcare is that by moving across local authority boundaries his access to insulin became more challenging. To overcome this the DSN team provided him with medication, and delivered prescriptions to him.

15.25 It is unfortunate that Jack had to move areas. This may have made a complex case more complicated still. It is understood that finding accommodation for someone like Jack is challenging and compromises may be required but his case is a reminder to all agencies of the need to consider very carefully the impact of out of area placements, especially on those with specific health needs.

16. Safeguarding and other Adult Social Care Interventions

16.1 Jack was subject to two adult safeguarding concerns and a section 9 referral to Middlesbrough Adult Social Care during the review period. There were also four requests for service during the period. Other safeguarding concerns were also raised about him during his adult life. The original SAR referral provided a detailed history of his prior involvement with Adult Social Care:

Jack first became known to Adult Social Care as a request for service - 11.02.2021 and progressed to a new case. Conversations were held with housing and was closed on the 05.03.2021 due to Jack not wanting support from Adult Social Care, and that his needs were around housing. Jack was living with his family at the time. Adult Social Care attended a repeat attender's conference at James Cook Hospital and Jack's case was reopened to the local authority to try and encourage engagement and offer social support in order to manage his diabetes. Jack's mum was also to be offered a carer's assessment … The diabetic nurse reported having a good relationship with Jack and he was closed to Adult Social Care on the 15.4.21, and was reported to be managing his diabetes better following multiple hospital admissions.

16.2 Notes from STHFT report that they submitted a safeguarding concern for self-neglect on 12th August 2022. This presumably went to the Stockton Safeguarding Team which explains why it is not in the above account.

16.3 The two safeguarding concerns during the review period were submitted within two days of each other on 26th and 28th September 2022. One was from a Diabetes Nurse the other was from another part of STHFT. The first of these was treated as a request for service. The second resulted in a referral to the Duty Worker but he was discharged before he was seen.

16.4 At least two possible missed opportunities to raise a safeguarding concern are identified. The SAR notification notes that in December 2022 he was evicted from a property due to damage and comments that "*Safeguarding were not made aware*". NTHFT

acknowledge that at the point of an admission to Hospital, a safeguarding concern could have been raised and *may have provided the opportunity to discuss (his insulin regimen) with him and his family.*

16.5 His GP also notes that self-neglect does not appear to have been picked up consistently. It is possible that concerns could have been raised at other points in his care, but this is hard to specify.

16.6 The question this raises is whether all workers identified Jack's poor management of diabetes as self-neglect. Given the number of points at which, for example, he lost accommodation and the number of actual referrals it seems that this is a gap in the safeguarding process. Indeed, Middlesbrough Adult Social Care highlighted the need for further self-neglect training.

16.7 The Section 9 referral was received in December 2022. This resulted in an assessment on 13th December which found that he had no eligible needs. Nonetheless, he was kept open to Adult Social Care on the Wellbeing Principle. The work with him would probably then have progressed to a multi-agency meeting. However, he died before this could move forward.

17. Using the Mental Capacity Act and other Legal Options

The Mental Capacity Act

17.1 Jack's mental capacity is mentioned at a number of points in the agency reports. For example:

- Middlesbrough Adult Social Care comment that: *There is evidence that the allocated social worker assessed Jack's capacity to manage his diabetes.*
- The STHFT IMR notes that: *In the case of Jack, although his capacity may often have been temporarily influenced by his mismanagement of his insulin or his substance misuse, when key decisions regarding treatment were necessary, he agreed with and was compliant with the treatment.*
- TEWV note that in September 2022: *There was a plan for a TEWV Associate Nurse Consultant to review Jack's medication before being discharged... However, Jack had gone off the ward to 'smoke' and had not returned. Prior to this he had held a conversation with the staff to say he wanted to go home. Having appraised clinical care records, discussion with ward staff (who had liaised with the acute hospital safeguarding team for advice) it was presumed that Jack had capacity to make decisions about his then care and treatment...*

17.2 At no point was Jack assessed or viewed as lacking the capacity to care for himself. This report cannot "re-assess" his capacity; however, it can raise questions about these decisions.

17.3 Jack may understand and retain information about his problems. He may be able to communicate decisions. What he does not seem to be able to do is to use or weigh information. He does not take the steps that he states are required to protect himself e.g. to eat, stay hydrated and manage his medication. In the case of some people with substance use disorders, they fail to do this because of the compulsion associated with drug or alcohol dependency. This concept is specifically acknowledged in section 4.22 of the current Code of Practice on the Mental Capacity Act.

17.4 Therefore, in assessing capacity with vulnerable and self-neglecting individuals like Jack it is important to consider executive function. The local Carol SAR[10] (about a chronic dependent drinker) talks about the need to look at whether someone can both *make* a decision and *put it into effect* (i.e. use information).

17.5 This will necessitate a longer-term view when assessing capacity with someone like Jack. Repeated refusals or failures of care should raise questions about the ability to put decisions into effect. The new draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function and to consider repeated failed decisions when assessing capacity.

17.6 Ultimately, even if it is argued that Jack is capacitated, this should not be the end of his care. The report of *The 2013 Mental Capacity Act 2005: Post-Legislative Scrutiny*, criticises the use of the Act in this way: *The presumption of capacity…is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm.*[11] The MCA Code of Practice repeatedly highlights the need to assist capacitous people with their decision making[12] or to undertake *further investigation in such circumstances.*[13]

Other Legal Options

17.7 Other legal options are available when dealing with complex individuals. For example: the Mental Health Act, an application to the High Court for Inherent Jurisdiction or, alternatively, use of the Human Rights Act.

17.8 It is unlikely that a case could have been made that Jack's situation warranted either the use of the Mental Health Act or Inherent Jurisdiction. TEWV specifically state that a Mental Health Act assessment was not identified as required. It might have been possible to move beyond this and build a case for action on the need to preserve his Article 2 rights under the Human Rights Act – the right to life. (Or indeed Article 3 – freedom from degrading treatment). This is not a widely used approach, but, in Manchester, the Substance Misuse Social Work Team is using the Human Rights Act to drive intervention with individuals where other frameworks have not proven viable. This is a route that may be worth consideration in similar cases.

18. Cognitive Impairment

18.1 There is growing concern that cognitive impairment, particularly acquired brain injury (ABI), is a factor in the presentation of many of the people who are subject to SARs. In 2022, Mark Holloway and Aly Norman published their article *"Just a little bit of history repeating: the recurring and fatal consequences of lacking professional knowledge of acquired brain injury"*[14] Since then they report that they have found another 20 more SARs about people with an ABI, where the SAR identifies that the impact of the ABI upon functioning was not picked up and responded to.

18.2 At no point was Jack seen as someone with a cognitive impairment, therefore, it is hard to take this theme too far. However, Jack did have a traumatic subarachnoid haemorrhage following an assault in 2021 and a head injury with the loss of consciousness following a fall at home complicating DKA in 2022. His mother commented on his poor cognitive functioning after these injuries.

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[10] Carol SAR
[11] Mental Capacity Act 2005: Post-Legislative Scrutiny 2013 105
[12] Mental Capacity Act 2005: *Code of Practice 1.2*
[13] Mental Capacity Act 2005: *Code of Practice 2.11*
[14] *The Journal of Adult Protection*, Vol. 24 No. 2, pp. 66-89. https://doi.org/10.1108/JAP-10-2021-0036

18.3 This review cannot re-diagnose Jack, so the impact of cognitive impairment is unknown; however, this is a reminder of the importance of considering cognitive functioning with individuals who require safeguarding.

19. Smoking

19.1 Jack was a longstanding cigarette smoker, even before he started smoking cannabis at the age of 11 or 12. The Lung Clinic stated that he had the *"lung age of a 92 year old"*.

19.2 This is a minor issue in this SAR but it is important that agencies consider the impact of smoking from two perspectives:

- the prevalence of smoking and its specific impact on the health of people with diabetes.
- the heightened risk of accidental fire and fire death in people with drug and alcohol problems.

19.3 Evidence indicates that smokers are at greater risk of complications from diabetes e.g. smoking:

- accelerates vascular damage in people with diabetes
- can make regulating insulin levels more difficult because high levels of nicotine can lessen the effectiveness of insulin, causing smokers to need more insulin to regulate blood sugar levels.
- has an adverse impact on the development of diabetic nephropathy
- is a potential risk factor for diabetic retinopathy (disorders of the retina)

19.4 On the other side, Professor Michael Preston-Shoot's *Analysis of Safeguarding Adult Reviews* examined 231 SARs from 2017-2019, 19 of the deaths involved were due to fire.[15] Accidents related to smoking will be a key risk factor. This highlights the importance of a focus on fire safety with vulnerable individuals.

19.5 It is not clear whether any particular steps were taken to address Jack's smoking and encourage smoking cessation. NTHFT acknowledge that although Jack's smoking status was identified, there was no evidence of smoking cessation advice or support.

19.6 Expecting Jack to immediately give up smoking may be unrealistic; however, it would have been possible to help him switch to vaping. Promoting vaping may be an opportunity to both address potential health problems and reduce fire risk. Addressing smoking could have been a positive step towards health promotion and engagement with Jack.

20. Covid 19

20.1 At the time of Jack's death the main Covid restrictions had been lifted. It is, therefore, not possible to draw a direct line between his death and the pandemic. However, Jack's adulthood was largely spent under the Covid restrictions. It is hard to determine the impact that this had on his life. The only reference in the agency reports to the impact of Covid is that Jack stopped engaging with Drug and Alcohol Services and vocational training during Covid and began using substances. This is clearly a negative impact; however, it is possible that the "Everybody In" policy helped Jack to access accommodation as an adult.

[15] Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 (local.gov.uk)

20.2 Nonetheless, this report can only acknowledge the possible impact of Covid. Given that circumstances are now very different, it is hard to argue that changes are required as a result of what happened during that period.

21. Family Involvement

21.1 Jack's mother was his main carer as a child. Jack also had a younger sister in the care of his mother. Jack's father was known by services to have his own needs because of drug use. The key question is whether his mother had adequate support during Jack's adulthood?

21.2 Good practice is identifiable:

- The family had had a consistent GP and were, and continue to be, supported by the practice with both their health needs and referrals to other services.
- Middlesbrough's Housing Department also commented that Jack's mother and sister have been supported throughout. Jack's mother was given parenting advice around substance use and how to deal with conflict. Support was given to his mother around accessing employment training.

21.3 In particular, since Jack's death the Young Person's Drug and Alcohol Worker has maintained a trusting, working relationship with both Jack's mother and his sister. The Worker has acted as the nominated person for family liaison, having worked with the family, when Jack was younger.

21.4 However, there were missed opportunities around family involvement.

- NTHFT say that: *Jack was a capacitated adult on admission and no discussions were recorded with his family…*
- STHFT highlight that during a March 2022 review by the DSN Team Jack was adamant that his family could not be informed of his admissions or contact with Hospital staff. They state that "his feelings had to be respected due to his capacity around the decision making". However, in August 2022 at another DSN review he was happy for family to be involved in communication, and later on 6th December 2022 he asked DSN team to contact family to request they bring his things to the Hospital for him.
- TEWV tried to contact Jack's nearest relative (his mother) on the number provided but there was no answer or means to leave a message. The Trust's Early Learning Review recorded a lesson learned for practitioners to consider regarding contacting a nearest relative.
- Middlesbrough Adult Social Care report that Social Workers also contacted his mother to try and establish contact with Jack, however it is clear from the review of his records that this contact was limited to trying to locate Jack rather than involving her in the meetings or assessments that took place. They reflect that there was not a consistent Social Worker that Jack's mother knew to contact and that there could have possibly been better family links in order to explore additional support options for her. Support options could have included a carers assessment or carer support to assist her with managing her concerns for Jack. (NB A Carers' Assessment does appear to have been offered by Adult Social Care in early 2021 prior to the review period.)

21.5 Efforts were made to engage and support Jack's mother. However, it is clear that more could have been done. This is simply an ongoing reminder of the need to "think family" in all care processes.

22. Comparison to Josh SAR

22.1 Jack's situation shares similarities with a previous TSAB SAR (Josh). In particular, they were both young men with a history of diabetes and homelessness. The SAR also describes Josh as having *ongoing substance misuse (which) brought him to the attention of criminal justice systems*. In addition, the SAR describes adverse childhood experiences.

22.2 However, there are also differences. Although Josh also had multiple Hospital admissions some of these were for deliberate overdoses on insulin rather than simply poor management of his diabetes and medication.

22.3 The SAB, therefore, were interested in learning whether lessons have been learned and whether system barriers and challenges remain from Josh's case.

22.4 The first point that needs to be emphasised is that Josh highlights that Jack is not alone in having a challenging pattern of substance use disorders and diabetes. The DNS highlighted that there are also other people in a similar situation. This underlines the need to learn lessons from these two cases.

22.5 The full learning points from the Josh SAR have been included at appendix 3. Below are particular themes that have emerged as requiring ongoing attention because they are also reflected in the Jack SAR. Material from the Josh SAR is included in italics.

22.6 *TSAB should produce a learning briefing regarding information about homelessness and the new legislation as well as duty to refer for all agencies. The briefing should cover support and advocacy that can be offered. (Learning Points 1, 2 &3)* The use of the Duty to Refer is discussed in section 15 of this report. Jack's care continues to suggest that work is required on the use of this legislative requirement.

22.7 The Josh SAR raises a series of learning points about the use of the Mental Capacity Act e.g. *Learning Point 8: People may not have 'agency and control' over their decision making. Learning Points 9* particularly emphasises this theme in the context of substance use. Section 17 of this report highlights similar concerns about the use of Act with people with substance use disorders. This highlights the importance of ongoing training on this theme.

22.8 *Learning Points 6, 12 and 9* emphasise the importance of *multi-agency working*. This report makes the same point in section 14 again suggesting a need for further work on this theme.

22.9 *Learning points 11-16* consider safeguarding and self-neglect. In particular, *Learning Point 11: Self neglect is a complex issue. Practitioners need an in-depth understanding in order to improve safeguarding of people who self-neglect in this way.* This report again identifies the importance of a broad understanding of self-neglect including substance use disorders and self-neglect.

22.10 Finally *Learning point 17* highlights the importance of *Communication between professionals and family.* This theme is addressed in section 21 of this SAR. Jack's family were offered support (and have been offered ongoing support). Nonetheless this does underline the importance of an ongoing focus on encouraging and supporting family work.

23. Key Learning Points

23.1 Jack highlights the challenges posed by someone who had diabetes in conjunction with a drug use disorder and homelessness, underpinned by a pattern of behaviour that meant

services found him difficult to engage. His life and agencies' efforts to care for him, therefore, highlight a number of key learning points.

23.2 The central theme is whether Jack should have received a greater level of support as he transitioned into and through young adulthood. It would be possible to argue that, for example, all Children In Need who reach 18 should receive ongoing support (as do Looked After Children). However, this may be too resource intensive and may be unnecessary for many young people. However, Jack does highlight that those at the greatest risk may benefit from a continuation of the more intensive support that they received in childhood. The question is how far does that definition of "at the greatest risk" extend?

23.3 Strictly within the context of this report, there is a strong argument that young people with poor management of their diabetes and, in particular, in conjunction with substance use are particularly at risk and may require more intensive follow up. Young adults using substances are also at particular risk of exploitation by dealers and could be another group for more intensive follow-up. This list could be extended much further. How far it extends and which categories of risk are prioritised is essentially a "political" decision. However, some young people beyond the looked after system do need more intensive follow up.

23.4 Jack's care is a reminder of the importance of a robust response to substance use disorders. A key part of this is to ensure that all generic services identify and address substance use disorders at the earliest point. This will require the widespread and consistent use of drug and alcohol screening tools such as DUDIT, Assist-Lite or AUDIT.

23.5 Although Jack's substance use remained unresolved at the end of his life, he had a positive engagement with Drug and Alcohol Services. The central learning appears to be that as both a young person and as an adult, the approach that was most effective with him was assertive outreach.

23.6 As with substance use, the specialist management of Jack's diabetes was very positive and, indeed, assertive. The simple message, which is repeated from the Josh SAR, is that agencies generally need to be regularly reminded of the very specific needs of people with diabetes.

23.7 The fundamental challenge with Jack was not that he had a drug use disorder or diabetes or that he was homeless. The real challenge was that services found it difficult to engage him into the care he needed for those problems. This is a pattern and a problem that is so common that it requires a very specific response of its own.

23.8 At the organisational level, it highlights the need for a published, multi-agency procedure to guide professionals in dealing with non-engagement.

23.9 This will need to cover themes including:

- Multi-agency management
- Assertive outreach
- Guidance on engagement techniques
- The need for a longer term view of the situation.

23.10 In the short period of his adult life, Jack became very difficult to house due to his behaviour. A frequent comment in both the IMRs and the Practitioners' Event was the lack of local residential options for vulnerable people, people with challenging presentations and those with diabetes in particular. It is likely that these messages would be heard in most parts of the country. This SAR can do no more than flag up the problem of under-funding of the housing sector.

23.11 However, Jack's case does highlight two specific issues:

- Discharge from Hospital to homelessness
- The problem of moving authority

23.12 Both Jack and the Josh SAR raises the question of whether the duty to refer homeless people, particularly in the Hospital setting, is being used appropriately. This is again an area for ongoing messaging and training.

23.13 At one point, because of a personal issue, Jack's only accommodation option appeared to be a move out of Middlesbrough to a similar facility in Stockton. It is positive that he was accommodated rather than refused a place completely. However, services do need to understand the additional challenges posed for someone like Jack by moving into another area. At the Practitioners' Event it was acknowledged that this may not have been the best decision for him. It is a reminder of the need to carefully consider the impact of out of area placements.

23.14 Jack was subject to two adult safeguarding concerns and a section 9 referral to Middlesbrough Adult Social Care during the review period. There were also four requests for service during the period. Other safeguarding concerns were raised about him during his adult life. As a result, work was undertaken to safeguard him and more widely to assess and address his care and support needs. In response to the various requests for service he received practical support from Social Workers in both Middlesbrough and Stockton.

23.15 However, at least two possible missed opportunities to raise a safeguarding concern are identified. His GP also notes that self-neglect does not appear to have been picked up consistently. It is possible that concerns could have been raised at other points in his care. The question this raises is whether all workers identified Jack's poor management of diabetes as self-neglect. Indeed, Middlesbrough Adult Social Care has highlighted the need for self-neglect training. This is further endorsed by the learning from the Josh SAR. TSAB already commission self-neglect training, which is delivered in a webinar, this report highlights the need to promote this further.

23.16 At no point was Jack assessed or viewed as lacking the capacity to care for himself. This report cannot "re-assess" his capacity; however it can raise questions about these decisions.

23.17 Jack may have understood and retained information about his problems. He may have been able to communicate decisions. What he did not seem to be able to do is to use or weigh information. He did not take the steps that he stated were required to protect himself e.g. to eat, stay hydrated and manage his medication. Therefore, in assessing capacity with vulnerable and self-neglecting individuals like Jack, it is important to consider executive function. Can someone both *make* a decision and *put it into effect* (i.e. use information)? This will necessitate a longer-term view when assessing capacity with someone like him. Repeated refusals or failures of care should raise questions about the ability to *execute* decisions.

23.18 As similarly indicated in the Josh SAR, this seems to highlight a need for ongoing training around the use of the Act. This should also include the use of other legal options that are available when dealing with complex individuals. For example, use of the Human Rights Act.

23.19 There is growing concern that cognitive impairment, particularly acquired brain injury, is a factor in the presentation of many of the people who are the subject of SARs. At no point was Jack diagnosed as someone with a cognitive impairment; however, he did suffer at least

two serious head injuries. This is a reminder of the importance of considering cognitive functioning with individuals who require safeguarding.

23.20 Jack was a longstanding cigarette smoker. This is a minor issue in this SAR but it is important that agencies consider the impact of smoking because of the range of associated risks and its complicating effect on diabetes. Addressing smoking could have been a positive step towards health promotion and engagement with Jack.

24. Good Practice

24.1 Many agencies made efforts to help Jack. Most professionals appear to have worked appropriately with him within the framework of their individual disciplines. However, both the agency reports and the Practitioners' event have highlighted specific examples of good practice:

- The work of both the Paediatric and Adult Diabetes Nurses is an example of best practice in working with a long-term condition. In particular, the focus on ensuring a successful transition is a model for all transitions.

- The Young People's Drug and Alcohol Worker who supported Jack and, subsequently, his family is an example of practice that goes beyond expectations.

- The Drug and Alcohol Services generally were proactive and supportive in working with Jack. It should be noted that a quiet space for reflection has been set up in the Drug and Alcohol Service in memory of him.

25. Recommendations

25.1 This section sets out the recommendation from this SAR. In addition, some agencies have made their own recommendations in their Agency Review Reports, TSAB should seek assurance that action plans are underway, and outcomes are impact assessed within those organisations.

Recommendation A

The Safeguarding Adult Board should lead local discussions on whether there are specific groups of young people (other than looked after children) who require ongoing support as they transition into adulthood. This should specifically consider the needs of young people with poorly managed diabetes and/or substance use disorders.

Recommendation B

Public Health Commissioners who commission and plan the development of Drug and Alcohol Services should ensure that all frontline services are aware of, and are able to use, robust drug and alcohol screening tools such as the DUDIT, AUDIT or Assist-Lite tools to identify and record the level of substance related risk in individuals.

Recommendation C

Public Health Commissioners who commission and plan the development of Drug and Alcohol Services should review whether the specific needs and impacts of people with substance use disorders that practitioners find difficult to engage in mainstream services are addressed in any future commissioning plans. In particular, investment in assertive outreach capacity for this group should be considered locally.

Recommendation D

The Safeguarding Adult Board should lead the development of local procedures that guide professionals on how to respond to individuals requiring safeguarding but whom agencies find difficult to engage. (These protocols could equally apply to vulnerable people outside of the safeguarding context).

Recommendation E

The Safeguarding Adult Board should ensure that those procedures include the option of assertive outreach and recognise the need to escalate the more vulnerable individuals, that services find hard to engage, to a local multi-agency forum for joint management. The SAB should ensure that the importance of escalating concerns about more vulnerable individuals is cascaded as widely as possible through their own and partner agency communication systems.

Recommendation F

The Safeguarding Adult Board should reassure itself that the Duty to Refer in the Homelessness Reduction Act 2017 is being consistently and appropriately used by all appropriate services.

Recommendation G

The Safeguarding Adult Board should lead discussions about the need for more, and more appropriate, housing for people with complex presentations, particularly those who are difficult to manage in services.

Recommendation H

The Safeguarding Adult Board should remind housing professionals to carefully consider the risks associated with placing a vulnerable person out of area.

Recommendation I

The Safeguarding Adult Board should ensure that there is ongoing training and messaging to highlight that both poorly managed diabetes and some patterns of substance use are a form of self-neglect and that there is a need to raise safeguarding concerns about such individuals.

Recommendation J

The Safeguarding Adult Board should ensure that training and guidance are available to support professionals to consider the use of the Mental Capacity Act in the context of people that agencies find difficult to engage generally. This should include reminders about the importance of considering whether someone can both take a decision and put it into effect.

Recommendation K

The Safeguarding Adult Board should ensure that work is taking place to highlight and address the impact of acquired brain injury on people who require safeguarding.

Recommendation L

The Public Health Team should ensure that all frontline services are aware of the importance of addressing smoking with vulnerable individuals because of the associated health and fire risks.

Appendix 1 - Key Lines of Enquiry

The following themes were identified as Key Lines of Enquiry for the report:

- Multi-agency working to support young adults who are deemed not to meet the Care Act criteria for care and support needs
- Self-Neglect linked to diabetes and substance misuse
- Barriers for homeless people and risks linked to diabetes
- Accommodation issues due to lack of appropriate housing / housing providers not accepting individuals
- Cross boundary complexities
- Hospital discharges when an individual may be homeless
- Out of hours support services
- Sharing of information and multi-agency communication.

Appendix 2 - Diabetes

The following section on diabetes has been taken directly from material provided by STHFT

1) Diabetes Mellitus is a syndrome characterised by raised blood glucose level associated with a deficiency or lack of effectiveness of insulin (a hormone secreted by the pancreas). Insulin secretion is dependent on the level of glucose in the blood. Following the ingestion of food, glucose levels rise, and insulin is secreted facilitating the glucose to enter the cells to be utilised for energy. Excess glucose is stored in the liver, muscles and as body fat. With insufficient insulin, a body cannot utilise its glucose which accumulates in the blood, spilling over into urine. In Type 1 diabetes mellitus a person is dependent on insulin medication and without it would eventually die, conversely in Type 2 diabetes mellitus a person may or may not be receiving some insulin, but could live without it.

2) Insulin as a medication is a solution which is injected just beneath the skin; it may be long acting delivering a steady background level over a 24 hour period; short acting over several hours to cover food ingestion or a mixture of both. Storage of insulin that is not in use should be in the refrigerator; in the absence of a refrigerator it can be kept at room temperature (15-25 degrees Celsius) for 28 days to remain effective. In use insulin cartridges should not be refrigerated and

3) Long term complications of diabetes can be divided into small vessel disease (affecting eyes, kidneys and sensory loss to peripheral nerves) and large vessel disease (affecting circulation to heart, brain and feet). Damage to the skin of the feet in the presence of both small and large vessel disease is one reason for amputations in people with diabetes.

4) There are two diabetic emergencies; 1. Hypoglycaemia which occurs when blood glucose falls low; this could be caused by the administration of too much insulin, missed or delayed meals, alcohol or excessive exercise. Treatment for hypoglycaemia is either oral glucose or intravenous (IV) dextrose. Glucagon may be given intramuscularly (IM) in the absence of IV dextrose; this a hormone produced by the pancreas that causes stored glucose to be released; 2. Diabetic ketoacidosis (DKA) which occurs when there is insufficient insulin in the body and fat stores have to be utilised for energy which produces a chemical called ketones. DKA can be caused by illness increasing a

person's insulin requirement, vomiting, uncontrolled or undiagnosed diabetes. Treatment for DKA is IV infusion of fluids and insulin in response to the regularly monitored level of glucose. Without treatment for DKA a person will become drowsy and then fall into a coma and potentially die.

Appendix 3 – Key Learning Points from Josh SAR

Learning Point 1: Housing staff are better able to meet the needs of homeless people if they are fully appraised of the circumstances related to the person.
Learning Point 2: There is a benefit to homeless people when non housing professionals have a basic understanding of homeless processes.
Learning Point 3: Staff that are known and trusted by a person can act as an advocate to help people navigate difficult to understand systems.
Learning Point 4: Multi Agency Processes can be more effective when underpinned by a shared protocol.
Learning Point 5: Management of frequent attenders should consider the reasons for attendance as well as plans for preventing/limiting attendance.
Learning Point 6: Frequent attender meetings may have more successful outcomes if they attract a broader number of agencies, are outcome focussed, have set review dates, produce minutes and plans shared to all relevant agencies (not just attendees).
Learning Point 7: Understanding lifestyle can support a deeper understanding of decision making and Mental Capacity.
Learning Point 8: People may not have 'agency and control' over their decision making
Learning Point 9: Multi agency working can ensure that all knowable information is shared and may lead to a better understanding of the impact of substance misuse and lifestyle on mental capacity and decision making.
Learning Point 10: Commissioning processes can cause difficulties in effective multi agency working and provision of seamless services
Learning Point 11: Self neglect is a complex issue. Practitioners need an in-depth understanding in order to improve safeguarding of people who self-neglect in this way.
Learning Point 12: Procedures and protocols provide frameworks for multi-agency working
Learning Point 13: All agencies must understand safeguarding processes and offer challenge when it appears that referrals are not responded to in the way expected.
Learning Point 14: Where there are multiple roles in a multi-disciplinary team, it is important that when team members are employed by another agency and they have a specific role (i.e. Social worker) that team members are clear on those roles and recording is carried out on the appropriate system so that statutory and other assessment information is available to other social workers in receipt of referrals.
Learning Point 15: Those with statutory responsibilities under the Care Act should be able to evidence an understanding of the various sections of that Act and offer support and guidance to others.
Learning Point 16: It is important to recognise the skills of organisational safeguarding leads and to approach them for advice and support.
Learning Point 17: Person centred and outcome focussed plans ensure that adults' own wishes can be explored in depth towards achieving their desired outcomes.