Shropshire Safeguarding Community Partnership

Safeguarding Adult Review

Sophie

Report Authors: Lisa Gardner & Laura Fisher

Contents

A tribute to Sophie from her Family.

Sophie was born on the 13th of March 1987. She had a younger brother, and her early life was spent at the family home. Her maternal grandparents were a huge part of both Sophie and her brother's formative years. They often did the school pick up and spent lots of time with them both.

From a very young age, Sophie was quiet and shy. She struggled to make friends. Following primary School, Sophie went to a boarding school from the age of 11 to 13. These were good years and Sophie began to come out of her shell. Sophie then moved to another school where she continued to gain confidence and build friendships. Sophie's House Mistress and Teacher wrote to Sophie's family that a lovely individual had been lost following Sophie's death.

Sophie was academically very bright. She was naturally studious and achieved good results. She chose not to study for A levels and instead took the International Baccalaureate, a demanding syllabus at which she excelled.

Her physics master, said Sophie was one of the most natural physicists that he'd ever taught, and that his memories of Sophie are the sort that evoke a big smile; she was bright, incisive and had a twinkle in her eye as she asked a difficult question or teased a response. He wrote that he always found Sophie to be really bright and fantastically 'edgy' - it is the challenging and inquisitive approach which keeps teachers on their toes and improves the level of discussion going on. He has only had a handful of students like Sophie, and it has always been a real treat.

After school, Sophie decided against taking science further. Instead, she went on to read English Literature at University.

Growing up, there were family holidays to Aberdovey, Cornwall, Suffolk and Yorkshire, to Egypt, Portugal, Scotland and to London. Sophie enjoyed visiting museums such as the V & A. She also enjoyed holidaying with her mum and with her friends. Sophie and her mum were very close but, following illness Sophie's mum's own health led this relationship to change in recent years.

Sophie's parents separated (and later divorced) when Sophie was in her last year of secondary school, this was a difficult time for Sophie.

Sophie's father later met and married Sophie's stepmother. Sophie gained two stepsisters through this marriage.

After university, Sophie was unsure of a career path so took some time temping while staying with her mother and brother at the family home. At this time, Sophie coxed at a Rowing Club, getting up at the crack of dawn on Saturday mornings, come rain or shine, for training sessions and to attend regattas.

She then took a role at a Local Council as part of the Building Schools for the Future programme. Sophie's job was to secure government funding and then put out tenders

for the companies who bid to build the schools. This led her into project management and, when her mentor resigned, Sophie took a job project managing for a nuclear plant. Sophie was a hard worker. She set herself challenges and was high achieving, both whilst in education and in the world of work. Sophie was a conscientious worker and a perfectionist, which would often lead to her putting pressure on herself. She was very committed to her job and decided to put down roots by buying her own house in Yorkshire. Sophie was very highly thought of by her colleagues.

Sophie was very troubled, but also very brave. She had her demons. At some point her life, which could have been viewed as perfect from the outside, took a self-destructive turn. She was a natural introvert who often lived in the past, ruminating and looking over her shoulder. Always looking for reasons to explain her negative feelings.

Sophie was desperately unhappy at the way her life had unfolded and was absorbed with feelings of hopelessness and worthlessness.

Sophie's mental anguish led to her finding solace in alcohol and following one such episode she fell down the stairs at her home in Yorkshire and broke her neck in two places. Her Dad brought her home to Shropshire for some TLC and support, but sadly her alcoholism made it very difficult.

The family found it almost impossible to access the professional help and care that Sophie clearly needed. As a result, she spent the last year of her life staying in temporary accommodation under the care of the Local Authorities, but close to her father and stepmum. Throughout her life Sophie had strong opinions but found these challenged when her own situation led her to homelessness. Her time with others in similar circumstances brought out a kinder, compassionate side to her demeanor and she became a much-loved member of her new community.

One of her friends from her time in temporary accommodation wrote "It was like a tight family unit at the accommodation, and everyone really did put a lot of time and energy into each other's lives, both residents and staff, and Sophie was a huge part of that family unit".

"Sophie played a huge part in my life and supported me daily with little messages or walks with the dog. At times I felt I couldn't go on and Sophie was there for me. I will always remember the friendship she gave, and I am privileged to have known her so well".

1. INTRODUCTION

Sophie was a 35-year-old single female who lived in Shrewsbury. She was known to have care and support needs due to her mental and physical health and had a history of severe difficulties with alcohol which had associated impacts upon her life, health and wellbeing. Sophie was found deceased in her own home on the 24th January 2023 by her stepmother. She had only recently moved to the property after spending time in various units of temporary accommodation. In the short period leading up to her death, Sophie had frequently attended her local Emergency Department (via ambulance) due to being intoxicated, sometimes with bruising she could not explain. Sophie would then regularly discharge herself as soon as possible.

The Shropshire Safeguarding Community Partnership extends its condolences to Sophie's family for their loss as well as its thanks for their contribution to this review process. Sophie's family have requested that her real name be used for this review. They have met with the author and provided information for this review.

2. SAFEGUARDING ADULT REVIEWS

In Shropshire the Safeguarding Adult Board is known as Shropshire Safeguarding Community Partnership (this is a joint partnership with Children's Safeguarding and Community Safety). Under Section 44 of the Care Act 2014, the Partnership has a statutory duty to undertake a Safeguarding Adult Review if the following criteria is met:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) *there is reasonable cause for concern about how the Safeguarding Adult Board, members of it or other persons with relevant functions worked together to safeguard the adult, and*

b) *the adult had died, and the Safeguarding Adult Board knows or suspects that the death resulted from abuse or neglect…, or*

c) *the adult is still alive, and the Safeguarding Adult Board knows or suspects that the adult has experienced serious abuse or neglect.*

The Safeguarding Adult Board may also –

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

…Each member of the Safeguarding Adult Board must co-operate in and contribute to the carrying out of a review under this section with a view to –

a) identifying the lessons to be learnt from the adult's case, and

b) applying those lessons to future cases.

There is further information about the Safeguarding Adult Review process and how agencies involved in the process should work together to learn lessons and disseminate learning on the Shropshire Safeguarding Community Partnership Website.

The purpose of a Safeguarding Adult Review is to identify areas for further learning so that we may identify ways of improving service provision. The purpose of a Safeguarding Adult Review is not to apportion blame or establish culpability.

Sophie's death was referred to the Shropshire Safeguarding Community Partnership for consideration of a Safeguarding Adult Review on 31st January 2023. An initial scoping meeting took place in early March 2023 and the Safeguarding Adult Review Panel recommended that the criteria had been met for a Safeguarding Adult Review. The Independent Chair then concluded that the criteria had been met. The rationale for this decision was that Sophie had care and support needs and died most likely as a result of self-neglecting behaviour and in circumstances where there were concerns about the way in which agencies worked together to safeguard her.

There was some initial learning identified from this scoping meeting which individual agencies agreed to undertake. From this meeting the Terms of Reference were produced [please see section 3.4 below].

This Safeguarding Adult Review has been produced by Lisa Gardner and Laura Fisher. Lisa Gardner is a Development Officer within the Shropshire Safeguarding Community Partnership Business Unit. She has been co-ordinating Safeguarding Adult Reviews since she joined the Business Unit in 2020 and has authored a review which has recently been published. Lisa has no direct involvement with any of the agencies who worked with Sophie. Laura Fisher is the Head of Service for Housing, Resettlement and Independent Living and brings her extensive knowledge and experience in this area to the process.

3. TERMS OF REFERENCE & SCOPE OF REVIEW

The period covered by this review is 1st February 2022 until the date that Sophie was found deceased in her home by her step-mum on 24th January 2023. During this period of time, Sophie was known to have contact with statutory and independent sector agencies.

The agencies contributing to the review were:

- West Mercia Police

- West Midlands Ambulance Service
- Pontsbury and Worthen Medical Practice (GP)
- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH)
- Shrewsbury and Telford Hospital NHS Trust (SaTH)
- Midlands Partnership NHS Foundation Trust (MPFT)
- Shropshire Council - Housing Services
- Shropshire Council - Adult Social Care & Adult Safeguarding Team
- Shropshire Recovery Partnership/ We are with you
- Walsall and Wolverhampton Probation Service
- Willowdene – an independent sector rehabilitation support agency

METHODOLOGY

There was learning identified in the initial scoping meeting, which is included within the body of this report, therefore the terms of reference focused specifically on the areas that needed to be explored further.

All agencies involved were asked to complete a detailed Individual Management Report and Chronology. These reports were submitted and presented by the authors in a meeting to ensure further opportunity for reflection and learning.

Local and national research into identified areas of learning within this review have been appraised and will be referenced.

The authors also had contact with some of practitioners who worked directly with Sophie to ask them about their involvement and experience of working with Sophie during the scoping period.

TERMS OF REFERENCE

The specific terms of reference for this Safeguarding Adult Review are:

1. How did agencies coordinate their response to Sophie when she was intoxicated and presenting a significant risk to her wellbeing? What improvements can be made for the future?

2. Did your agency have engagement with Sophie's family? What help was offered to them as individuals supporting someone with Sophie's complex needs?

3. How well was information shared about Sophie's needs for care and support and any associated risks by your agency? How well do you think other agencies shared information with your organisation? Was there any good practice that can be shared and what can be improved for the future?

4. Do you think that Sophie being a self-funder had an impact on service engagement/support available from Shropshire Council? If so, please explain the rationale for this and what could be done differently if anything. [Shropshire Council]

5. In what circumstances would your agency convene a multi-disciplinary meeting to discuss an individual? Do you know why one was not called regarding Sophie?

6. How effective was the identification of her mental health needs and support?

7. How effective were adult safeguarding referrals?

8. Did practitioners use the Shropshire Safeguarding Community Partnership 'Responding to Self-neglect Guidance'[i] to support their decision making when working with Sophie?

9. Which practitioners in your agency have the necessary understanding of section 13(4) of the Mental Health Act and its potential use [Shropshire Council & Midlands Partnership University Foundation NHS Trust only]

10. How well was the impact of pain and management of injuries understood and managed as part of Sophie's needs? [for GP, SATH, RJAH only]

11. During times of crisis various agencies were contacted to get support for Sophie. How did the most appropriate agency responses impact the care she was provided at those times?

12. How effectively were Issues pertaining to prescribing in relation to alcohol misuse managed? [SATH, GP, MPFT, SRP]

13. How the "How to use Legal Powers to Safeguard Highly Vulnerable Dependent Drinkers in England and Wales[ii]" and the "Blue Light Practitioner Manual[iii]" could be utilised to inform recommendations.

14. How Adult Safeguarding and homelessness briefing: Positive Practice[iv] could be used to inform recommendations? [Shropshire Council only]

4. COMBINED AGENCY CHRONOLOGY

1987	Sophie Land born.
2004	Sophie's parents divorced.
September 2013	Sophie started work in the nuclear energy industry in Yorkshire.

December 2013	Sophie's Mum suffered a stroke with associated brain injuries which affects her ability to show her feelings and empathy.
2018	Sophie started to take increased amounts of sick leave from work and suffered a decline in her mental health. She became increasing fearful that she would be sacked and eventually resigned.
2018 – 2020	Sophie remained living in North Yorkshire.
December 2020	It is believed that Sophie was drinking heavily at this point and it is likely that this is when she fell down the stairs and damaged her neck. Dad travelled to North Yorkshire on 19.12.2020 and bought Sophie back to Shropshire. She remained in Shropshire for approx. 1 month.
03.02.2021	Police were called due to Sophie's lack of contact with Mum or Dad and Sophie was found unconscious in her home. Her Dad once again travelled to North Yorkshire on the 04.02.2021 to bring Sophie back to Shropshire. Sophie continued to drink heavily and stayed between her Dad's and Mum's during this time. She also attended an appointment due to the ongoing pain in her neck and was advised there was very little that could be done to treat this.
February 2021	Sophie was open to Midlands Partnership University Foundation Trust being treated for generalised anxiety disorder, depression and agoraphobia with episodes of self-harm such as cutting, burning and biting.
April 2021	Sophie's step-mum contacted Adult Social Care to arrange an appointment. It was agreed that Sophie was eligible for a Care Act Assessment. No further contact was made until July 2021 when 5 calls were made to Sophie over a 2-month period. There were no responses by Sophie to these calls and the case was closed in September 2021.
30.07.2021	Sophie was arrested for drink driving and her Mum advised she could no longer stay with her. Sophie went to stay at her grandmother's house in Walsall (grandmother had gone into a care home). On 31.08.2021 her mum went to the property but could not gain entry. Her Dad attended and eventually gained entry where Sophie was found very drunk surrounded by various empty bottles of alcohol. Sophie went to stay with her Dad following this incident.
September 2021	Sophie was allocated a worker with Shropshire Recovery Partnership. She remained with the same worker until her death.
27.09.2021	Sophie attended court regarding her drink driving offence and was given a 12-month Community Order. Sophie stayed with her Mum with no

	incidents of alcohol abuse. She returned to stay with her Dad on 03.10.2021.
30.10.2021	Sophie went back to her Mum's for a period but unfortunately another incident occurred where it was suspected Sophie, whilst intoxicated had fallen once more and broke her clavicle. Her Dad transported her to Royal Shrewsbury Hospital where the injury was considered serious and she was referred to Robert Jones Agnes Hunt Orthopaedic Hospital for surgery.
November 2021	Sophie attended appointments at Robert Jones and Agnes Hunt Orthopaedic Hospital. Initially there were concerns about the treatment options to resolve Sophie's fractured clavicle due to the ongoing issues with her neck injury. Eventually Sophie had an operation on her collar bone on 19.11.2021. Although the operation was deemed to be a success, Sophie reported she was left with significant pain in her collar bone as well as the ongoing pain she was suffering regarding her neck.
December 2021	Sophie continued to drink, citing the need to do this when her pain medication did not help with the ongoing pain she was suffering. On 24.12.2021 her Dad took her to the emergency department of the Royal Shrewsbury Hospital due to another alcohol related incident. She was discharged on Christmas Day 2021.
25.12.2021	Sophie alleged that her Dad grabbed her arm and pulled her down the stairs. She also indicated she experienced emotional abuse. She disclosed this in March 2022 during an admission to hospital. A safeguarding referral was made however as she was no longer living with her father at the point of disclosure the risk was deemed low.
January 2022	Sophie booked herself into a private rehabilitation centre for alcohol addiction. She stayed for approximately 4 weeks. Feedback from her stay was that she struggled to fully engage due to the ongoing pain she was in. During Sophie's stay in the private rehabilitation centre her step-mum contacted the Local Authority asking for support for Sophie with her mental health and housing when she was discharged. At the time she was on a waiting list for Improving Access to Psychological therapies and waiting for a medication review with Midlands Partnership University Foundation NHS Trust.
February 2022	Sophie registered as homeless with the Local Authority. Sophie's Dad resigned from work to take care of her.

	Her GP contacted the Local Authority asking for Sophie to receive support from the Mental Health Social Work Team. The letter confirmed Sophie was suffering from depression, low self-esteem, and anxiety as well as ongoing pain and alcohol addiction. The Mental Health Social Work Team determined her needs were related to alcohol and housing and signposted her to other agencies. Though this was without a full assessment being completed.
March 2022	Shropshire Recovery Partnership referred Sophie to the Mental Health Social Work Team who again concluded her needs were related to alcohol and housing and the referral was closed.
01.03.2022	Sophie moved into a supported accommodation facility (recommended by Shropshire Recovery Partnership). However, started drinking again immediately.
03.03.2022	Sophie was admitted to Royal Shrewsbury Hospital after being found unconscious at the supported housing facility. She remained in hospital for approx. 3 weeks. The first week was in order to detox and the 2 following weeks was due to her contracting Covid 19.
08.03.2022	A telephone homelessness assessment was carried out by the Housing Options Team.
19.03.2022	Sophie requested a review by the Mental Health Liaison Team based at Shrewsbury and Telford Hospital Trust as she was feeling low in mood. She was encouraged to contact Mental Health Outreach.
23.03.2022	Sophie was discharged from hospital and moved into Housing Options Temporary Accommodation.
31.03.2022	Midlands Partnership Foundation Trust received a referral from Shropshire Recovery Partnership stating Sophie was low in mood and isolating herself. She had also expressed suicidal ideations in the past 24 hours. A full psychological assessment was completed, and Sophie was referred to the Community Intervention Pathway with an appointment arranged for 12.04.2022.
12.04.2022	Sophie did not attend her appointment with the Community Intervention Pathway.
13.04.2022	Sophie's Dad received a call because Sophie was wandering in the local area in a state of undress – The ambulance service took Sophie to the emergency department of Royal Shrewsbury Hospital.

16.04.2022	Sophie's Dad and step mum attended temporary accommodation due to being unable to contact Sophie. She was found unconscious in her room and an ambulance was called. Paramedics stayed with Sophie for 4 hours to stabilise her, and she remained at the temporary accommodation placement.
19.04.2022	Sophie was moved to an alternative temporary accommodation placement.
April – October 2022	Sophie continued to stay in temporary accommodation. When the hotel was fully booked, she would move out and stay with her Dad and step mum. During this time, she abstained from alcohol. During April and May 2022 Sophie had regular contact with the Community Intervention Pathway.
11.05.2022	Sophie attended a hub appointment with Adult Social Care who undertook a Care Act assessment. Sophie had eligible needs relating to maintaining and managing nutrition, managing personal hygiene, managing a habitable home and being able to make use of the home safely. The social worker said she would make a referral to Occupational Therapy team and develop a support plan and transfer Sophie to the central social work team.
May and June 2022	Numerous contacts were attempted with Sophie to discuss her Care Act Assessment and needs. Willowdene eventually updated the team who advised that Sophie would need to make contact when she was out of temporary accommodation and her case was closed 01.07.2022.
08.06.2022	Sophie had a Community Intervention Pathway assessment and reported being 53 days sober.
11.10.2022	Shropshire Recovery Partnership referred Sophie to Adult Social Care due to her physical health needs. A hub appointment was made for 22.11.2022 which Sophie did not attend. Sophie's step Mum rang Adult Social Care during this time to update that Sophie was drinking again and she believed she was drinking hand sanitiser. She was advised to refer Sophie to Shropshire Recovery Partnership.
13.10.2022	Sophie was moved to another temporary accommodation placement.
26.10.2022	Sophie suffered a seizure and an ambulance was called. She declined admittance to hospital.
28.10.2022	Sophie had a medical review and reported being 190 days sober (this contradicted the suspicions reported by Sophie's step mum).

28.10.2022	Lettings officer from Homes Plus contacted Sophie by phone to complete the verification form and checks. Sophie asked for permission to have a cat which Homes Plus agreed on 31.10.2022 by email.
05.11.2022 and 30.11.2022	Sophie relapsed on 5th November 2022 and again on 30th November 2022. She was admitted to Royal Shrewsbury Hospital where burns were found on the back of her legs. It was thought that the likely cause of the burns was by her lying too close to a radiator whilst unconscious due to intoxication.
30.11.2022-01.12.2022	Sophie was seen by Mental Health Liaison Team at Royal Shrewsbury Hospital following admittance due to intoxication. She was put on waiting list for Life Skills which is an independent living training programme.
02.12.2022	Homes Plus contacted Sophie to advise property due to be ready to view and signed for the week commencing 12/12/22.
06.12.2022	Sophie was discharged from hospital.
15.12.2022	Sophie suffered numerous fits whilst in the temporary accommodation. She did not want to be admitted to hospital on this occasion and Dad stayed with her at the hotel to assist with supporting her to eat and remain hydrated with the intention of taking her to the GP the next day.
16.12.2022	Sophie viewed 8 Longden Close (Homes Plus property) and signed the tenancy. The property was in a poor condition with no central heating connected, no carpets, the bathroom smelt of urine, the property smelt musty, there was a broken light in the bedroom and the waste pipe was blocked in the bathroom. The décor was of low quality and due to the central heating not being connected Sophie returned to her temporary accommodation placement over the Christmas / New Year period whilst repairs were undertaken. Sophie also attended an appointment with her GP where she was referred to a neurologist.
21.12.2022	Sophie was again found unconscious in her temporary accommodation hotel room. Her Dad transported her to the emergency department of Royal Shrewsbury Hospital due to an ambulance strike being held that day.
22.12.2022	Step mum Carol called Homes Plus to see if they would turn the gas on as Sophie is in hospital and may come out to a property that has no heating. Homes Plus advised she needs to set up an account with an energy supplier as she would need to get a card for the electrics, and that a 'turn on and test' would not be possible until after New Year.

21-28.12.2022	Both Sophie's Dad and step mum rang Adult Social Care several times whilst Sophie was in hospital to express their concerns about her on discharge and to advise that they felt she needed to be sectioned (assessed for detention under the Mental Health Act).
28.12.2022	Sophie was discharged from hospital. She was still unable to move into her tenancy and so returned to the temporary accommodation placement.
29.12.2022	Sophie called Homes Plus to say she has contacted British Gas to get her gas uncapped. Homes Plus advised that a 'turn on and test' would be booked in the New Year. Sophie agreed to call back in January.
03.01.2023	Sophie called Homes Plus to book a 'turn on and test' and reported her bedroom light was not working. Appointment booked for 05.01.2023.
04.01.2023	'Turn on and test' and repair to bedroom light moved forward to 04.01.2024. Sophie rang to advise shower was blocked but was advised this was tenant responsibility.
04.01.2023	Sophie returned to stay with her Dad due to the Council asking her to leave her temporary accommodation placement.
09.01.2023	Sophie called Homes Plus to say her basin drain was blocked. Appointment booked for 11.01.2023.
11.01.2023	Sophie attended her property at 8 Longden Close but suffered a seizure. Dad took her home again rather than her staying at the property alone. Sophie then returned to the property 12.01.2023 stating she would try and get some sleep. Dad spoke to her on 13.01.2023 and then visited on 14.01.2023 (Sophie was sober on both occasions).
16.01.2023	Sophie's step mum attended her property and found her to be drunk. Her Dad later attended the property where Sophie continued to be drunk. Dad and Step Mum made various attempts to contact Sophie over the next few days but after a limited response her step mum attended on 20.01.2023 and again found her to be drunk.
21.01.2023	The ambulance service attended Sophie who was highly intoxicated, due to Sophie's property being unsecured the ambulance service contacted the police to secure it. The police contacted Dad to advise that Sophie had been found intoxicated and had been taken to the emergency department of the Royal Shrewsbury Hospital and that the property needed securing. Sophie's dad went to Sophie's property to secure it whilst Sophie was transported to hospital. Sophie was reported to be covered with bruises of differing ages, heavily intoxicated and temporarily lacked capacity

	regarding decisions about her care needs. The ambulance service made a safeguarding referral.
22.01.2023	Sophie discharged herself from the hospital.
23.01.2023	Sophie contacted her Dad asking him to collect her from the Hospital – he declined. A taxi driver that had collected her from the hospital called 999 as he felt she was unsteady on her feet and had been incontinent. When the ambulance crew arrived, Sophie was found to be unable to communicate and lacked capacity about her care needs and was taken back to the Royal Shrewsbury Hospital.
23.01.2023	Neighbour called Homes Plus to report that Sophie had entered her property, taken money and slapped her across the face and said next time she would use a knife.
24.01.2023	Sophie's step mum tried to get in contact with her. After repeatedly being unable to, she attended her property where she found Sophie deceased. Death was confirmed at 16:43.

5. EVIDENCE BASE

Alcohol dependence and self-neglect

There are numerous health risks associated with drinking alcohol including cancer, heart disease, reduced life expectancy, accidents and injuries. Each of these risks increase as the amount of alcohol that is consumed increases. Current guidelines to keep health risks from drinking alcohol at a low level are to consume no more than 14 units of alcohol a week[v]. If you do drink 14 units a week regularly then these units should be spread evenly over 3 or more days. Examples of 2 units of alcohol could be a pint of normal strength beer, lager or cider and a medium glass of wine. A single measure of a spirit or liqueur is 1 unit.

In 2021 The Health Survey for England[vi] found that 28% of men and 15% of women had drunk over 14 units in the week prior to responding to the survey. 5% of men and 2% of women had drunk over 50 units in the week prior to answering the survey.

The Care and Support Statutory Guidance defines self-neglect as 'a wide range of behaviour, neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'. (DHSC: 2023:14.17). The risk to the adult and others is greater when they are refusing services that would mitigate the risk of harm to themselves or others. (Preston-Shoot:2018).

Research often refers to three types of self-neglect; lack of self-care, lack of care of one's environment and refusal of services that could alleviate issues connected to self-care or care of the environment. Individuals who are alcohol dependent are arguably lacking in self-care. Their dependence on alcohol will make it difficult for them to care for their own environment and they often refuse services. Despite this, referrals to safeguarding are often not made for individuals who are alcohol dependent as there is a misconception that self-neglect related to alcohol is an "unwise decision made with full mental capacity, and this negates the need for a self-neglect referral".[vii]

In the National Analysis of Safeguarding Adult Reviews 2017-2019[viii] it was noted that an individual would be assessed by professionals as being at risk due to their alcohol dependence. This would be the focus of an assessment and management plan to reduce the risk of harm. Even if this person had multiple hospital admissions or repeatedly refused support services it was often not recognised that they were self-neglecting.

In Learning from tragedies' analysis of alcohol-related Safeguarding Adult Reviews (2019), it was stated that "the failure to properly recognise or understand the relationship between alcohol misuse and other forms of self-neglect can create a serious blockage in care and treatment pathways".[ix]

By alcohol dependence not being recognised as self-neglect, it means that professionals are not utilising and applying the wealth of research available both nationally and locally regarding how to respond to individuals who self-neglect. This was evident in the Individual Management Reports submitted by agencies involved in the care of Sophie.

Mental Capacity Assessments

Assessing the capacity of a dependent drinker can be complex for professionals. This may be equated to the mistaken view that alcohol addiction is a "lifestyle choice". However, their freedom of choice to cease the behaviour is largely taken away from them due to their addiction.

The Mental Capacity Act Code of Practice states: *"for the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain"*.[x]

The accepted guidance for assessing someone's mental capacity is to consider the following elements in this order:

1. Is the person able to make a decision?
If they cannot:

2. Is there an impairment or disturbance in the functioning of person's mind or brain? If so:
3. Is the person's inability to make the decision because of the identified impairment or disturbance?

The symptoms of alcohol and drug use are given as examples of impairments or disturbance in the functioning of the mind or brain within the Code of Practice. However, practitioners also need to consider if the impairment is related to acute intoxication or a more long-term impairment of Alcohol-related brain damage. Under the Mental Capacity Act if there is no impairment of the brain or mind then the individual will not lack capacity.

There are times when an individual who is a chronic or dependent drinker is clearly unable to make a specific decision, such as when they are unconscious and therefore unable to consent to medical treatment. This then requires professionals to make a best interest decision for them and there were occasions when this was done for Sophie. However, when it comes to assessing a dependent drinkers mental capacity following a potential life-threatening situation, for example, to continue medical treatment, accept support or an assessment of need, this becomes more complex.

When someone has an addiction, it will impact their ability to put their decisions into action. Mental capacity assessments are time and decision specific; it can be wrongly assumed that individuals have mental capacity. This is because individuals are often able to communicate their decisions (sometimes very articulately), however they are not able to follow these through. The functional part of Mental Capacity Assessment is determined by a four-stage test:

1. Does the person have a general understanding of what decision they need to make and why they need to make it?
2. Does the person have a general understanding of the likely consequences of making, or not making, this decision?
3. Is the person able to understand, retain, use and weigh up the information relevant to the decision?
4. Can the person communicate their decision (by talking, using sign language or any other means)?

Therefore, someone who is alcohol dependent may well be able to "talk the talk but not walk the walk". This relates to someone's executive functioning. Therefore, when someone is not carrying out the actions identified in their decision making (not walking the walk) it is important for professionals to explore deeper as to why this is. Using the Mental Capacity Act to support them to do this can prevent the individual being at risk. "[xi]

The National Institute for Care Excellence recommends that when assessing capacity of an individual who appears to have executive dysfunction it is important to include

observations of the individual's decision-making ability and functioning rather than just talking to them. This should then be followed up with discussions with them about if they can use and weigh up information as well as understand any risks that have been encountered. Assessments of dependent drinkers' mental capacity should be viewed as "marathons, not sprints" (Ward, M 2021).

Professionals fully recording their assessments of an individual's mental capacity is of paramount importance. Michael Preston-Shoot (2019), in his analysis of Safeguarding Adult Reviews April 2017- March 2019[xii] noted that professionals recording of mental capacity assessments were poor. Often there was no information regarding how an assessment that someone had mental capacity to make a specific decision was conducted. The London Network of Nurses and Midwives, in their guide to front line practitioners note that professionals need to understand that simply recording "has capacity" is not sufficient or adequate and will not protect them in a court of law.[xiii]

Trauma informed practice

The Department of Levelling up, Housing and Communities (2022)[xiv] carried out a Rapid Evidence Assessment of trauma informed approaches to supporting people experiencing multiple disadvantage. Within this assessment, it was noted that there is no one single definition of what trauma informed practice is. However, there is an understanding, across various pieces of literature written on the subject, that there are some key principles. These are:

- To take a trauma lens (recognising that people may have experienced trauma which can impact how they feel, think and behave, and responding accordingly);
- Prevent future re-traumatisation;
- Ensure safety;
- Take a strengths-based approach (what people can do for themselves);
- Build trust.

Ultimately professionals from different agencies having differing understanding of what trauma informed practice is, can create a barrier. Some professionals think that to be trauma informed they simply must listen to an individual. However, true trauma informed practice is much more than this. It is about hearing a person's story and understanding how this has impacted their thoughts, feelings and behaviours. When there is a difference in the understanding of the approach across professionals working with people who have experienced trauma, it can lead to mismanagement of their needs.

The Department of Levelling up, Housing and Communities Rapid Evidence Assessment did find that when done effectively, working with individuals who face multiple disadvantages in a trauma informed way can have a significant positive impact on the person's health and wellbeing. This was particularly the case for those

identified in the criminal justice system, mental health sector, women's sector and housing and homelessness sector. Improvements were seen in the individual's relationships, engagement with services and their behaviours.

If professionals were to approach all those they met, with the mindset of "what's happened to you" opposed to "what's wrong with you" then this is the starting point of being trauma informed. This short video on trauma informed practice can show how these practices can open doors to those who have experienced trauma and may appear to be harder to reach Opening Doors: Trauma Informed Practice for the Workforce on Vimeo.

6. ANALYSIS

The analysis section of this report is going to explore the Safeguarding Adult Review's terms of reference in turn. It will look at the evidence presented to the panel and highlights good practice as well as any learning.

How did agencies coordinate their response to Sophie when she was intoxicated and presenting a significant risk to her wellbeing? What improvements can be made for the future?

West Mercia Police had two face to face interactions with Sophie. The first was on the 30.03.22 following her key worker from Shropshire Recovery Partnership requesting support. Sophie had not been seen for five days and it was known that she had relapsed into drinking. She was in her bedroom, in the hotel and not responding. The key worker had called the police on the 28.03.22 and the log had been closed after the key worker reported that someone from the hotel had spoken to Sophie through the door. On 30.03.22 police attended after a further call from the keyworker and Sophie was seen safe and well by an officer. She stated she had no intentions of harming herself.

No Adult Protection Investigation was recorded. An Adult Protection Investigation is an internal process within the police. This is when an officer attends an incident when no crime has been committed but there are adult protection concerns. The Adult Protection Investigation is recorded alongside a risk assessment and these are tagged for the attention of the Harm Assessment Unit to consider if referrals are needed to other agencies. The officer was aware that Sophie was open to Shropshire Recovery Partnership but not any other agencies. An Adult Protection Investigation in this instance could have led to a referral being made to Adult Social Care.

On the 13.04.22 police received a call from the ambulance service due to Sophie walking around the street naked. Police attended the Hotel and found Sophie in her room. Sophie was intoxicated, conscious and breathing, but not engaging. West Midlands Ambulance Service arrived, and Sophie was left with the paramedics. An

Adult Protection Incident and Adult Risk Assessment were completed and reviewed by the Harm Assessment Unit. The Harm Assessment Unit deemed that no onward referrals were needed as Sophie was in the care of the paramedics who would complete the necessary referrals as per agreed local protocols. No referrals were made.

We recommend that this local protocol, regarding onward referrals for support and safeguarding, should be reviewed to ensure that it is fit for purpose and meets the needs of adults with care and support needs in Shropshire.

West Midlands Ambulance Service attended to Sophie on seven occasions during the scoping period. Six of these were when she was intoxicated. It was only on the 16.04.22 that the ambulance crew deemed Sophie to have capacity to make decisions about her own care and treatment. On that occasion, Sophie refused to go to hospital even after the ambulance crew explained the risks to her. Sophie remained at home with her step-mum and prior to leaving, the ambulance crew spoke to the Crisis Team from the specialist mental health NHS Trust on the phone. A plan was made for Sophie to contact the Community Mental Health Team the following day to rearrange the appointment she had missed.

On the other occasions when the ambulance crews attended to Sophie, they deemed her not to have capacity to make her own decisions about care and treatment. This was because of her level of intoxication. They therefore took her to hospital. On the 21st, 22nd and 23rd of January 2023 the crews that attended to Sophie were concerned about her presentation and the state of her property and they made safeguarding referrals.

Sophie attended Shrewsbury Hospital intoxicated on seven occasions in the period relating to this review. Mental capacity assessments were conducted and when necessary a best interest decision was made in regard to Sophie's care and treatment until she regained capacity and was able to make her own decisions. Referrals were made for Sophie to speak with the Mental Health Liaison Team and Alcohol Liaison Team each time she was at the hospital. This input was to support her whilst she was admitted and regarding her discharge planning. The making of these referrals and Sophie being seen by the team during each admission is evidence of good practice.

In the last four days of Sophie's life she attended the Emergency Department of the hospital on four occasions. On the 20th January 2023, Sophie left the premises without being seen by a medical professional. So, after giving her name at the desk, where it would have been noted she was under the influence of alcohol, she then left the department before being triaged or assessed formally. The Emergency Department waiting area is a public area which is not staffed and therefore people who have attended and registered at reception are then free to leave if they wish. By leaving this meant there were no opportunities for medical staff to complete the initial assessments, including the Domestic Abuse Screening Tool or assess Sophie's

capacity to make decisions about her care and treatment. In these circumstances it was not possible to prevent Sophie from leaving the hospital prior to any assessments being carried out.

On the 22nd January 2023 Sophie was taken to the Emergency Department by ambulance however this does not automatically mean that someone will be taken to a cubicle, they are still required to be triaged and assessed formally. Sophie was seated in a waiting area to await this formal triage and assessment however left the hospital before this could take place.

On the 23rd January 2023 when Sophie attended the Emergency Department, a mental capacity assessment was completed, and it was assessed that Sophie lacked the capacity to consent to treatment. Therefore, a best interest decision was completed on her behalf. Sophie had a CT Scan which showed no intercranial bleeding. On returning from her scan, Sophie contacted a taxi and left the department. Staff contacted the police who declined to attend and passed the response to West Midlands Ambulance Service. Sophie was returned to the hospital by ambulance for further treatment. Including being seen by the Mental Health Mental Health Liaison Team.

On this occasion, when Sophie was clearly at risk and needed to remain at the hospital, the staff acted quickly and reported their concern to police for support. At any given time in an acute setting the staff within the Department are responding to multiple competing demands.

Midlands Partnership University Foundation NHS Trust's Mental Health Liaison Team saw Sophie each time she was admitted into hospital due to intoxication. They ensured that she was seen by the Alcohol Liaison Team and that her Shropshire Recovery Partnership worker was made aware of her admission. Prior to each discharge, the team ensured that there was a clear plan for mental health support for Sophie.

As admissions increased, the Mental Health Liaison Team recognised the need for additional support for Sophie through the Community Mental Health Service by way of the Life Skills Programme. Whilst with the team, Sophie indicated that the precursor for her drinking was the pain she experienced due to her neck injury. This information was relayed to those who could affect change in this area of her care and Sophie was advised to speak with her general practitioner on discharge about pain management.

On the 16.04.22 Sophie's step mum called the Crisis Team due to Sophie being intoxicated. It was correct that at that moment in time they were not the agency that could provide the most appropriate support. The plan made on speaking with the ambulance crew after they had attended, was for Sophie to contact the Community Mental Health Team the next day to rearrange her missed appointment. A follow up

call from the team to check on Sophie the following day could have been made but was not.

Sophie's worker from Shropshire Recovery Partnership raised concerns with the Police on the 28th and the 30th March 2022 about Sophie's welfare as she had not been seen for five days. The worker made various calls including to the hotel, hospitals, family and other agencies regarding Sophie's welfare. However, the keyworker did not go out to the Hotel to attempt to see Sophie or engage with her. Throughout the worker's relationship with Sophie, there is no record of any in person visits. This appears to have been a legacy of how work was conducted during COVID 19 despite the scoping period for this review being post COVID restrictions.

Following Sophie's death her family were made aware that she had made several purchases of alcohol from a local shop in the final days of her life. On some days there were multiple purchases made. It is likely, given the description received by others of Sophie's presentation during this period, that Sophie would have been visibly intoxicated and possibly in a state of undress. Section 141 of the Licensing Act 2003 states that "it is an offence to knowingly sell or attempt to sell alcohol to a person who is drunk or allow alcohol to be sold to someone who is drunk". There are challenges in applying this law; given the difficulties in proving that the person selling the alcohol was aware that the customer was drunk. However, it is an important piece of legislation as it allows police and licensing authorities to draw specific attention to the offences and remind licensees of their responsibilities under the Licensing Act 2003.

It is important to note here that the Licensing Team were never involved nor informed of any concerns about premises selling alcohol to Sophie prior to her death. Had they been informed, they would have been able to make enquiries with licensed premises about their selling practices. Therefore, as agencies involved with Sophie did not ask questions about where she was purchasing her alcohol the Licensing Team were unable to take direct action. To address this, we make the following recommendations:

We recommend that when agencies are working with individuals who drink alcohol to excess, they should where possible ask questions to enquire where the individual is sourcing the alcohol. If these enquiries identify any licensed premises, then the Licensing Team should be contacted and informed of this.

We recommend that the Licensing Team visit the shop where Sophie is known to have made some of her purchases and speak with them about this review and the potential implications of the sale of alcohol to people who appear to be intoxicated.

We recommend that the Licensing Team ensure that licensees are reminded of their responsibilities under Section 141 of the Licensing Act 2003 when they are sent their annual fee reminder email.

Did your agency have engagement with Sophie's family? What help was offered to them as individuals supporting someone with Sophie's complex needs?

Most of the agencies who worked with Sophie had some contact with members of Sophie's family. Sophie's stepmother was prevalent within records as someone who contacted services and supported Sophie at appointments throughout the scoping period. Sophie's father is noted to have raised concerns about his daughter's mental health and requested that she was sectioned under the Mental Health Act on one occasion.

What is clear is that agencies' engagement with Sophie's family was generally initiated by the family themselves. This was often when Sophie was in crisis as well as when Sophie was doing well, and they were supporting her to remain that way. At no point were the family offered a carers assessment or support as carers of someone with complex needs. There appears to be no evidence of the family being contacted for information to support care planning or assessing risk.

Leaving Sophie's family without appropriate support meant that they were not properly equipped to complex needs. The family said this left them feeling that they did not know where to turn and who to call upon at different times. When Sophie was in crisis, the family said they would phone a service for support and be told they were not the most appropriate agency for them to call. They would then be advised to call a different agency. This would lead to the family having to make another phone call whilst also managing Sophie at the same time.

Agencies have stated that there may have been some concerns about sharing information with family due to General Data Protection Regulations. This could have been easily and quickly resolved by asking Sophie's permission to share information with her stepmother and/or father. Practitioners should also remember that General Data Protection Regulations should not be a barrier to listening to information and concerns that family members have to share about a loved one.

Since Sophie's death the All Age Carers Strategy has been agreed. This outlines the local authority's vision to "identify, support and enable carers of all ages in Shropshire to remain healthy, fulfil their own potential and balance their caring responsibilities with a life outside caring". As well as this strategy, the Carers Team has been bought back in house within the Adult Social Care service. There was a thematic audit in June 2023 to look at carer assessments and from this an action plan has been generated. The actions above relating to the All Age Carers Strategy demonstrate that the Council are committed to changing the experience of carers and improve the advice, support and engagement with carers. This review further reinforces the evidence base regarding the need of these interventions.

Whilst the local authority is responsible for conducting carer assessments it is important that all agencies recognise carers and know where to sign post individuals for support.

To complement the existing learning briefing about carers, we recommend that a short video on how to recognise individuals with caring responsibilities and how to access appropriate support be created and hosted on YouTube.

In terms of recognising the need to support family carers as well as the potential working with the family has to improve outcomes for people who mis-use alcohol, Shropshire Recovery Partnership have employed three group workers for the service. One of the services they will provide is family and friends support groups for those who have a loved one addicted to a substance. These will be offered twice a week both virtually and in person. These sessions were previously offered but the take up was low. It is recognised that the advertising of these services by the agency to both individual family members and other organisations needs to be better to improve take up of this offer.

How well was information shared about Sophie's needs for care and support and any associated risks by your agency? How well do you think other agencies shared information with your organisation? Was there any good practice that can be shared and what can be improved for the future?

On analysing the information provided, it appears that agencies made attempts to share information with one another. There was liaison between agencies both at times of crisis and when Sophie was doing well. However, due to the complexities of Sophie's mental and physical health and her care and support needs it is evident that what was required was a multi-disciplinary meeting.

A multi-disciplinary meeting would have allowed all agencies to share the information they had about Sophies needs. This would have led to a collective understanding of the presenting needs and a shared assessment of the risks. A multi-agency risk assessment, as well as other plans would have been put into place to support Sophie and her family.

Had professionals been working within the guidelines of the Working with Risk Document the structure of the agenda would have led them to identify a Lead team and Lead Professional. Often the family were left making multiple calls to different agencies to ask for support and help or to get things, such as housing sorted out for Sophie. It would have been this individual who the family could have been in contact with to seek support and reassurance.

Midlands Partnership University Foundation NHS Trust have identified through their analysis into their involvement with Sophie that their internal communication needs to improve. As part of the Serious Incident process that is taking place, it will be

explored how information can be shared between primary and secondary mental health services to ensure that reviews of individuals mental health needs take place.

Sophie provided a lot of information on her housing application, including information about her back and neck injury, her mental health, the medications that she was taking and that she was being supported by Shropshire Recovery Partnership. During the verification process for her tenancy Sophie was very engaged with the Lettings Teams and gave them no cause for concern regarding her suitability for a property or being able to manage a tenancy. They had in-depth conversations and exchanged regular emails with Sophie. Due to this they did not feel there was a need to liaise with any other agency involved with Sophie regarding her needs as she had been clear about what support she was receiving and from whom. They did however make a referral to the Sustain Floating Support Service for Sophie who would be contacted within the first five days of her tenancy commencing to offer her support.

Do you think that Sophie being a self-funder had an impact on service engagement/supports available from Shropshire Council? Please explain the rationale for this and what could be done differently if anything? [Shropshire Council only]

Sophie had a Care Act Assessment on 11th May 2022 which established that she had eligible needs for support against the following four outcomes:

- Managing and maintaining nutrition
- Maintaining a habitable home environment
- Being able to make use of the home safely
- Maintaining personal hygiene

Sophie had savings which were over an specified amount which meant that she would have to self-fund the care and support that she was provided. It was however identified that she would need support to arrange this care.

Following the assessment taking place, Adult Social Care records show that the worker made attempts to contact Sophie through her advocate to discuss the support she needed. Attempts were also made to meet with Sophie to develop a support plan however Sophie did not respond to the communications that were made. This means there was no plan in place to meet Sophie's assessed needs. At a later point, a letter was sent to Sophie with the Care Act assessment saying that Adult Social Care were closing her case. Willowdene records indicate that it was communicated to them that Sophie should contact the Social Care Team once she was in permanent accommodation.

It is the view of the person who completed the Individual Management Report for Adult Social Care, that regardless of whether Sophie was self-funding or not, the approach taken by them to engage Sophie in support planning was not effective.

Sophie's life at this time was chaotic and therefore a more assertive outreach approach was required.

In what circumstances would your agency convene a multi-disciplinary meeting to discuss an individual? Do you know why one was not called regarding Sophie?

All those involved in providing the day-to-today support and care for Sophie have acknowledged that a multi-disciplinary meeting should have been called. They cannot provide a justifiable reason as to why one was not arranged.

Agencies should be following the Working with Risk and Responding to Self-neglect in Shropshire Guidance. Within these documents, it is clear that agencies should be convening a multi-disciplinary meeting at the earliest opportunity. Any agency can initiate the meeting and there is an agenda template to aid discussion.

It is clear from the Individual Management Reports and discussion in both the panel meeting and with practitioners that the Working with Risk and Responding to Self-Neglect in Shropshire are not sufficiently embedded. There is currently a multi-agency task and finish group working on updating the Responding to Self-Neglect in Shropshire Guidance. This includes the expectation of attendance at meetings when requested to support risk assessment and planning for individuals who are self-neglecting in its various guises.

Multi-agency risk management meetings are being held monthly as part of the Self-Neglect and Hoarding Forum. Practitioners can attend these and present an individual they are working with and get support and input from a multi-agency forum. The aim is to develop a Risk Management Plan for individuals who may sit outside of statutory frameworks (e.g. safeguarding) where there is a risk due to self-neglect. To attend one of these meetings practitioners need to begin completing the risk assessment document and send it to mentalhealthsocialwork@shropshire.gov.uk.

Midlands Partnership University Foundation NHS Trust have a new role within their Shropshire team that will have responsibility to embed the self-neglect agenda. They will support professionals to identify and respond to concerns of self-neglect and work to the current guidance. They will support their staff in arranging and coordinating multi-disciplinary meetings to address concerns of self-neglect. This is a positive step that has been taken in recognition of self-neglect being a significant issue in Shropshire.

As discussed above, where an individual is presenting with excessive alcohol consumption and it is suspected that they are sourcing their alcohol from a licensed premises, then the Licensing Team should be contacted. This team should also be involved in any multi-disciplinary meeting that is held with regard to any individual experiencing such alcohol consumption, if an officer from the team has not themselves called the meeting.

We recommend that there is a clear plan for launching the new version of the Self-Neglect Guidance. Each agency should demonstrate to the partnership how they are going to embed the guidance within their organisation and take responsibility for having a rolling programme of learning for new practitioners.

We recommend that a short video on convening multi-disciplinary meetings is created and shared widely across the partnership.

How effective was the identification of Sophie's mental health needs and the support she required?

Whilst all agencies that met Sophie acknowledge that she had mental health needs, there was not a clear consensus as to what those needs were. This impacted on the support she required and received. Shropshire Council's Mental Health Social Work Team were quick to draw the conclusion that Sophie did not meet the criteria for their team in February 2022. This without a full assessment being carried out instead given the information they had it was because they felt that Sophie's primary needs were housing and support for her alcohol dependency. However, they did not take into account that Sophie was awaiting an appointment with a psychiatrist. Further consideration about the impact her problem drinking had upon her mental health and general wellbeing would have been beneficial.

When Sophie was admitted to Shrewsbury and Telford Hospital NHS Trust in March 2022 for alcohol detoxification, she told staff that she was experiencing suicidal thoughts. An appropriate referral was made the Mental Health Liaison Team. Sophie was seen on the ward by the team throughout her stay and supported with her anxieties about discharge. Onward referrals were made for a community outreach support worker and Sophie was utilising "Silver Cloud", an online self-help support resource, whilst she awaited her appointment with Improving Access to Psychological Therapies (IAPT). IAPT was a programme which aimed to increase the access to psychological therapies for depression and anxiety by offering National Institute for Health and Care Excellence (NICE) recommended treatments.

The Mental Health Liaison Team ensured that they communicated with Shropshire Recovery Partnership; both to inform when Sophie had been admitted to hospital but also to support discharge planning. Towards the latter part of Sophie's life when the Mental Health Liaison Team identified an escalation in admissions to hospital, they ensured that she was referred for the Life Skills Programme to provide Sophie with additional support.

Sophie discussed with the Mental Health Liaison Team that the trigger for her alcohol consumption was the pain she experienced because of her neck injury. This information was shared to others involved in Sophie's care and she was advised to contact her general practitioner on discharge to discuss pain management options.

Sophie was supervised by the Probation Service between September 2021 and September 2022. Sophie had been sentenced to a 12-month Community Order with a Rehabilitation Activity requirement for the offence of Drink Drive. At the time of sentencing, Sophie was living in the Wolverhampton area and therefore her Supervision Order was allocated to Wolverhampton Probation Office. When Sophie moved to Shropshire, her order was not transferred to the Shropshire Probation Service due to uncertainties around Sophie's address following her discharge from a rehabilitation centre.

It is noted that Sophie had a good relationship with her offender manager. However, the lack of knowledge regarding local partnership arrangements meant that the offender manager could not ensure the appropriate support for Sophie in the same way they normally would. Sophie self-reported feelings of low mood throughout her order and it does not appear that the offender manager explored what agencies were available locally to support Sophie with her mental health.

There was a referral made by the offender manager to Willowdene, a commissioned service to provide support to women on probation. This referral requested that specific work was completed with Sophie around emotional wellbeing. Sophie engaged actively in this. However, given the complexity of Sophie's situation with her drug and alcohol misuse and the physical pain she endured daily, it would have been beneficial for the offender manager to check who was working with Sophie long term with regards to her mental health.

Sophie's recovery worker from Shropshire Recovery Partnership was aware of her mental health needs. They contacted the Mental Health Social Work Team about their concerns and tried to seek extra support for Sophie. They were also kept informed of Sophie's admissions to hospital by the Mental Health Liaison Team.

There was some information shared between agencies and liaison between others. With the number of agencies involved and the complexity of the situation, a multi-disciplinary meeting should have been called. This would have allowed for all those involved in the support and care of Sophie to share information and assess risk collectively. Multi-disciplinary meetings are the foundation for effective safeguarding. We have discussed above the steps being taken to address this area and have made a recommendation for partners to assure themselves that improvements are being made.

The Housing Provider were aware that Sophie suffered with depression and anxiety as she had declared this on her application. She also said during her conversations with them that she was apprehensive about taking up a tenancy. Due to this they made a referral to the Sustain Floating Support Service who would make contact with Sophie within five days of her tenancy starting and then weekly contact with her to support her with tenancy related matters. Sophie was contacted by Sustain but they appear to have not found a way to engage her.

How effective were adult safeguarding referrals?

On the 5th January 2022, Sophie disclosed to her offender manager that her dad had been unhappy due to her relapsing into alcohol use and felt she needed to move to her own home. Sophie reported that her dad had allegedly pulled her down the stairs and removed her from the house. He had also allegedly confiscated her phone leading to her missing a call from her offender manager. Sophie was in hospital at the time and would then be moving to a detoxification facility for three weeks, but it was not known where she would be going after that. The offender manager did not explore in more detail Sophies allegations nor make a safeguarding referral regarding the alleged physical violence Sophie disclosed from her dad. It would have been appropriate to do so given Dad's ongoing involvement in Sophie's care.

On the 7th March 2022 when Sophie was in Shrewsbury Hospital, she made the same disclosure to a member of the Mental Health Liaison Team. A safeguarding referral was made via Shropshire Council's First Point of Contact team. Sophie was spoken to alone by a safeguarding social worker while she was still in hospital. It was established that the alleged assault occurred in December 2021. Sophie would not be returning to live with her dad following discharge from hospital and therefore this was not considered to be an ongoing risk from the alleged source of harm.

It is positive to see that this incident was followed up with Sophie and she was spoken to alone. There does, however, appear to have been a lack of professional curiosity regarding Sophie and her dad's continued interactions and Sophie's reliance on his support including the need for family support. Therefore, the potential for ongoing risk was not explored effectively.

In the latter days of Sophie's life, she attended Shrewsbury Hospital Emergency Department four times in four days. Each time Sophie was highly intoxicated. On three of these occasions, she was brought to the department by ambulance. Each time the ambulance took Sophie to Emergency Department they raised a safeguarding referral due to the concerns they had about her living conditions and self-neglect. They did also notice some bruising on Sophie which they noted in the referral. The safeguarding adult team received and accepted the referral on the day that Sophie died.

Each time Sophie attended the emergency department, an initial Safeguarding and Domestic Abuse Screening Tool should have been completed. These are done to support staff in identifying any causes of concern at the earliest opportunity. At the time of Sophie's admissions these were completed on paper. The Trust will be moving an to electronic versions of these tools which will not allow staff to move through the tool without completing it or raising a concern. If staff do not raise a safeguarding concern having identified something they were worried about for example bruising, they will then have to justify why the concern wasn't progressed for example, the explanation for how the bruising occurred matched the type of bruise. The system will not let them move onto the next screen without doing so.

Staff within the emergency department raised a safeguarding concern to their safeguarding team during Sophie's third presentation. They identified the concern to be neglect rather than self-neglect, given the recurrent attendances and self-care issues the internal safeguarding team felt this was incorrect. Work has started with the Trust's Practice Education Facilitators to support staff to recognise self-neglect and use the Initial Safeguarding Screening Tool to help with this.

Did practitioners use the Shropshire Safeguarding Community Partnership Responding to Self-Neglect Guidance to support their decision making when working with Sophie?

There is no evidence provided from any agency that worked with Sophie to suggest that the Shropshire Safeguarding Community Partnership Responding to Self-neglect in Shropshire Guidance was utilised. This guidance has been in place since April 2019 and it is disappointing that it is again evident that it is not being used to support decision making.

At a recent multi-agency learning event, an anonymous voting platform was used to ask those in attendance about their use of the Responding to Self-neglect in Shropshire Guidance; they were only allowed to choose one option from the list available. Out of 162 responses, 59 people said they use it, 47 said they didn't know it existed, 45 said they didn't know where to find it, 4 said it is too long, 5 said it is too difficult to follow and 2 people said they did not agree with the guidance. Those present were given the contact details of someone within the Business Unit to give more detailed feedback on what they feel needs to be changed to make the guidance more accessible.

As discussed above, there is a group currently working on revising the guidance. This revision includes new tools for practitioners, and it will be going out for practitioner consultation shortly. We have made a recommendation regarding the need for this updated guidance needing to be properly embedded.

Which practitioners in your agency have the necessary understanding of section 13(4) of the MHA and its potential use [Shropshire Council & Midlands Partnership University Foundation Trust only]

Section 13 (4) of the Mental Health Act provides a person's Nearest Relative with the right to request that the local authority arrange for Mental Health Act Assessment to be carried out with a view to making an application for their relative's admission to hospital. This request can be made in writing or by phone. The local authority Approved Mental Health Professional Service must consider this request and provide a response; however, this does not mean that they will make an application for admission to hospital, but the Approved Mental Health Professional does have to "consider the patient's case". If after consideration the Approved Mental Health Professional decides not to conduct an assessment, they must inform the nearest

relative in writing of their reasons not to proceed. The Nearest Relative can also ask someone else to make the request on their behalf, for example a relative or someone working with the person. Any request made “on behalf of” the Nearest Relative will be responded to in the same way by the local authority Approved Mental Health Professional.

Section 26 of the Mental Health Act provides a list of who can act as a person’s Nearest Relative. For Sophie, this role would have been undertaken by her Dad as she wasn’t married, in a civil partnership nor did she have any children.

On the 22nd and 23rd of December 2022 Sophie’s step mum telephoned Adult Social Care to say that Sophie had been admitted into hospital again. Both she and Sophie’s dad were very concerned about Sophie being discharged from hospital when she was fit for discharge. This was due to Sophie stating that she had suicidal ideations. They felt that Sophie needed to be sectioned. During neither of these phone calls was Sophie’s step mum advised of S13(4) rights nor was consideration given to making a referral to the Approved Mental Health Professional team on behalf of the family for a Mental Health Act assessment to be undertaken.

The clinical notes from the Royal Shrewsbury Hospital indicate that on the 28th December Sophie’s dad expressed the same concerns and wished for Sophie to be sectioned if discharged. The ward staff made a referral to the Mental Health Liaison Team who saw Sophie on the ward later that day. It was identified that Sophie was open to the Community Mental Health Team and knew how to contact them for support. Sophie said that her dad had unrealistic expectations of mental health services. There were no concerns raised regarding Sophie’s capacity and she was discharged later that day.

It is not evident from the records that the Mental Health Liaison Team spoke directly with Sophie’s dad about his concerns. What is clear is that he was not made aware by anyone at the hospital about S13(4) and his rights as Sophie’s Nearest Relative.

Clinical staff at Midlands Partnership University Foundation NHS Trust complete Mental Health Act Training every three years. The rights of the Nearest Relative are outlined within this course. Compliance is monitored by the Trust Learning and Development Team.

The Approved Mental Health Professionals Team sit within Shropshire Council and they have knowledge and understanding of the 13(4). However, there was a potential request for a 13(4) made by Sophie’s step mum and neither the Social Care Practitioner nor her manager recognised this. The Principle Social Worker in Adult Social Care has recently delivered some learning events for all social care staff and has been seeking to enhance the knowledge base regarding S13(4) amongst those attending. This has led to the mental health training lead agreeing a programme of training and information on this area to build knowledge and understanding.

Whilst it is important that Adult Social Care and Midlands Partnership Foundation University NHS Trust have clear knowledge and understanding of this area; the panel felt that it was something that other professionals should know about as well.

Therefore, **we recommend that a learning briefing on S13(4) be developed and sent out across the partnership to aid understanding and help professionals to support families who care for loved ones with mental health issues. Agencies will need to demonstrate how they have used this with frontline professionals.**

How well was the impact of pain and management of injuries understood and managed as part of Sophie's needs? [for GP, SATH, RJAH only]

Sophie had significant injuries for which she did not seek treatment. X-Rays and MRI scans showed that Sophie had healing fractures to the thoracic vertebrae 1, cervical vertebra 2 and significant injuries to cervical vertebra in her back and neck. These injuries were most likely sustained when Sophie fell down the stairs whilst intoxicated. Sophie also sustained a fractured clavicle in another incident some months later, which required surgery.

Whilst under the care of the Robert Jones Agnes Hunt Orthopedic Hospital, the teams had a lot to consider in how to best manage the injuries to Sophie's neck and spine. Whilst surgery was an option to fix the malalignment and old non-united fractures, there were significant risks to this surgery. Sophie was not keen on the surgical option presented to her. When Sophie needed surgery for her fractured clavicle, there were concerns raised by the anesthetist due to the cervical spine fractures and how these would be managed in that surgery. This was resolved with an in-house professional's meeting, holding the meeting did delay the surgery by a few days.

Discussions in conjunction with Sophie, led to the decision to treat her neck and back injuries conservatively with a neck brace, pain medication and regular checkups. When Sophie was seen in clinic, her pain levels were discussed, and her general practitioner was kept up dated via a letter about actions that were taken. In May, July and October 2022, the hospital cancelled the scheduled appointments that they had with Sophie meaning she was not offered an appointment after seeing them in March until November. Sophie did attend this appointment, which was about her shoulder but did not attend the appointment later that month relating to her spine as she had COVID 19.

The hospital has identified that appointments which are cancelled by them require rescheduling in a timely manner to ensure patient safety and wellbeing.

On the occasions that Sophie was admitted to Shrewsbury and Telford Hospital NHS Trust, her pain as a result of her neck and back injuries were considered and reviews were undertaken. In December 2022 a CT and MRI scan were undertaken and Sophie was provided with a cervical neck collar. She was also referred to an

outpatient pain clinic to support her with her chronic pain management needs, records did indicate that she was known to the pain team. In addition to this, Sophie's medication was considered, reviewed and medications were prescribed to assist her in being more comfortable.

Sophies general practitioner referred Sophie to the pain management service in October 2021. Sophie, like many patients with chronic pain, continued to contact her general practice to manage her pain. The general practitioners Sophie spoke to would give her considerable time to discuss her concerns. However, there was significant concerns by the GP Practice that the analgesia Sophie was prescribed was not managing her pain and that it represented a dependency. Sophie would continually ask for her pain medication to be increased and her pain seemed to remain at a high level long after expected. The Practice was trying to strike a balance between managing her pain and safeguarding her from further addiction.

A number of studies[xv] have showed that the prolonged use of opioid pain medications can lead to patients being hyper-sensitive to pain and it can even make existing pain worse. Sophie told several professionals that she used alcohol to manage her pain. Withdrawal from prolonged alcohol use can also increase pain sensitivity[xvi]. When Sophie was not drinking following her successful detoxification and struggling with a high level of pain, this could have been due to this increased sensitivity. There is no evidence that this was considered.

We think that the understanding around Sophie's pain and the management of this could have been better understood if all those working with her had engaged in a multi-disciplinary meeting. Open and honest professional discussions could have been had about how to manage the potential risks of opioid addiction with Shropshire Recovery Partnership.

During times of crisis, various agencies were contacted to get support for Sophie. How did the most appropriate agency responses impact the care she was provided at those times?

On the 28th March 2022, Sophie's keyworker from Shropshire Recovery Partnership became concerned about her welfare. Sophie had not been seen over the weekend, she had not been in contact with her family and her mobile telephone was switched off. The keyworker called the police to report the concerns that she had for Sophie's welfare. The call taker advised that she contact local hospitals. This was done, but Sophie had not been admitted. This information was reported back to the police. Later that day the keyworker called the police back to inform them that someone from the hotel had been up to Sophie's room and knocked on the door. Sophie had responded verbally but she had still not been physically seen by anybody. The police log was closed following this, and it was recorded that there was no policing purpose therefore no further police response required. However, the keyworker does not appear to have been told that the log was being closed.

On the 30th March 2022 the keyworker called the police again asking for an update on their previous call. It was explained that this had been closed and the reason why. The keyworker called back shortly afterwards to request a safe and well check, as there were concerns for Sophie's mental health and she had problems with alcohol abuse. It was explained by the keyworker that Sophie did not have a social worker or anyone else who could go around. Police dispatched officers who spoke with Sophie, she was noted to be safe and well and had no intentions of harming herself.

It is not known why the keyworker did not go out themselves in the first instance, as both she and her manager have left the organisation. There was a two-day delay in the initial concern being raised and the police carrying out the welfare check. Beyond the police checking that Sophie was physically ok, they do not have the knowledge or training to support someone with her complex needs. Therefore, having someone with them from another agency who knew Sophie or had experience of individuals with addiction and mental health difficulties would have been of benefit. Had Sophie wanted support in that moment it could have been provided.

It was at this time that West Mercia Police, along with other police forces across the country, were reviewing their policy regarding police conducting 'safe and well checks' and what incidents the police should and should not attend. This was because the police were routinely contacted by partner agencies and members of the community to carry out "welfare checks" on a person they have a concern for. Police have been carrying these visits out often when they had no statutory responsibility to do so. Whilst these welfare checks were being carried out, other policing calls for which there is a legal policing purpose, were not being completed. Police officers are not medically trained nor are they trained in mental health or substance misuse support. They also have limited powers of entry to conduct welfare checks and the threshold is very high (Section 17 of the Police and Criminal Evidence Act (1984) indicates that officers can enter a property for the purposes of "saving life or limb or preventing serious damage to property").

From early 2022, call takers and police staff were being encouraged to direct callers to other appropriate agencies when receiving calls for safe and well checks and advise of other options that were available. This was whilst the practice was being reviewed and until the "Most Appropriate Agency Policy" was written. This was ratified and implemented in April 2023.

The implication of this is that agencies were doing what they have always done and requesting police support, and this was no longer forthcoming as officers' actions were in part being based upon the Most Appropriate Agency Policy. This was frustrating and confusing for partner agencies. It also led in this situation, to there being two days between the initial concern being raised and a safe and well check being carried out for Sophie in March 2022.

On 23rd January 2023, Sophie left the hospital in a taxi she had ordered herself, without being discharged. She had been assessed as not having the capacity to make her own decisions about care and treatment. The hospital informed the police of her leaving the hospital as Sophie's Glasgow Coma Score (a scale used to describe the consciousness of a patient) was very low. The police declined to attend, instead passing the response to West Midlands Ambulance Service.

Also, on that day, the police received a call at 15.52 from the taxi driver who collected Sophie from the hospital. He said he had picked someone up wearing a hospital gown and pajamas and dropped her off at Sophie's address. The driver stated that she had seemed confused and it smelt like she had "soiled herself", she had bruising and a cut to her face. Sophie's front door was unlocked, and she did not have a key. The driver said he had called adult safeguarding, but they had advised that he call the police. Adult Social Care have no record of this call from the taxi driver. One police call taker noted on the log that *"this was a medical issue – if informant has concerns, they will need to contact the appropriate agency*". Another call taker reviewed this and tried to make enquires with the hospital however they were unable to get through, so they called the ambulance service.

West Midlands Ambulance Service attended Sophie's property late that evening. The call they received from the police had been graded as a category three, these are urgent calls where someone needs treatment to relieve suffering. They may also require transportation to hospital, or they could be assessed and treated at the scene e.g. at the patients home. This was based on the information they had received which related to the call from the taxi driver. When the ambulance crew arrived at Sophie's property, they were able to enter as the door was unlocked. Sophie was non-verbal throughout the interaction and they took her back to Shrewsbury and Telford NHS Hospital.

The Police are not medically trained. Had they responded to the call from the hospital or the taxi driver and found Sophie non-verbal and highly intoxicated they would have had to call for an Ambulance. However, it is unclear if the communication of the severity of the situation was clearly communicated to ambulance service when they called. Sophie's Glasgow Coma Score was very low and her capacity to consent to treatment had been assessed as lacking. If this had been known, then this might have received a different grading.

What is clear, is that a taxi driver was concerned enough about the safety and wellbeing of one of his passengers and had the knowledge to call adult safeguarding. It is also clear that he was then left with the responsibility of ringing another agency for help. When members of the public call agencies for help it needs to be recognised that they will not understand internal policies. The taxi-drivers' actions were highly commendable. Often when the public have a concern they will turn to the police for help. This is because they are a recognised symbol of community safety and support.

Since early 2023 there has been a Safeguarding Advice Team set up within the Police Operational Call Centres to deal with safeguarding calls including concerns for welfare. This team's role is to support individuals to get the most appropriate agency response the "First Time and Every Time" (Most Appropriate Agency Policy).

Shrewsbury and Telford Hospitals NHS Trust have identified that they need to update their Missing Person Policy to reflect the police's Most Appropriate Agency Policy. This is because within the Trust's policy it states that when someone goes missing, in circumstances similar to Sophie's that they should call the police for support. This is in the process of being updated and a series of risk assessments will be used to inform who decision making about which agency should be contacted in what circumstances.

A briefing was held with in August 2022 with Senior and Chief Executive level partners about the proposed changes and all attendees were invited to share their concerns via a questionnaire, there was minimal response to this. It is of concern that the call takers had been encouraged to begin directing callers to other agencies from early 2022 when the Most Appropriate Agency Policy was not due to be implemented until April 2023. When an operational practice, or policy change that will impact other partners is proposed, then agencies should be given a notice period prior to implementation. **We recommend that the partnerships strategic leaders agree that when any one partner is planning the implementation of a policy such as the Most Appropriate Agency, the implantation does not begin until the specified date. This will support all agencies to ensure that they update their policies and prepare frontline staff for these changes.**

How effectively were Issues pertaining to prescribing in relation to alcohol misuse managed? [SATH, GP, MPFT, SRP]

Sophie was prescribed Thiamine[xvii] (this is prescribed to support the liver in people who are alcohol dependent) and Acamprosate[xviii] (to help prevent relapse in those who have successfully achieved abstinence from alcohol) by a non-medical prescriber at Shropshire Recovery Partnership in May 2022. At each of her key working appointments Sophie self-reported that she was taking her medication as prescribed.

When Sophie attended her psychiatrist appointment in October 2022, she was still abstinent from alcohol, but it is unclear if she was taking her Thiamine and Acamprosate. What is clear, is that Midlands Partnership University NHS Foundation Trust had not been made aware of this prescription by Shropshire Recovery Partnership's non-medical prescriber. When the psychiatrist reviewed Sophie's medication, they made a request to the GP that an increase be made to her antidepressant.

Within Shrewsbury and Telford Hospital NHS Trust there is an established alcohol withdrawal regime which is followed. All patients are referred to the alcohol liaison nurse for addition support and guidance as needed. Sophie had three periods of admission during the scoping period where the alcohol withdrawal regime was successfully completed.

Sophie's general practitioner stated in their Individual Management Report that they had no knowledge of Sophie being prescribed medication for her alcohol misuse. However, Shropshire Recovery Partnership sent the Practice a letter detailing the prescription on 8.12.22. *In order to ensure the safety of individuals Shropshire Recovery Partnership need to ensure that they are notifying all agencies who could potentially prescribe and administer medication to that person if they have been prescribed medication by their service.*

How the "How to use Legal Powers to Safeguard highly vulnerable dependent drinkers in England and Wales" and the "Blue Light Practitioner Manual" could be utilised to inform recommendations

These two documents have been produced to support practitioners and their managers who work with highly vulnerable dependent drinkers. It is important to be clear about terminology, dependent drinkers are those with an alcohol addiction and whose drinking means they have a physical dependency. This means they will need a managed withdrawal. Chronic dependent drinkers are those who have been dependent for a long time, often decades. A highly vulnerable dependent drinker is someone who presents a high risk to themselves or others partly due to their drinking and the impact it has on their wellbeing. These individuals will be those who are self-neglecting, making extensive use of the emergency services and often be seen to be rejecting or not engaging with alcohol treatment.

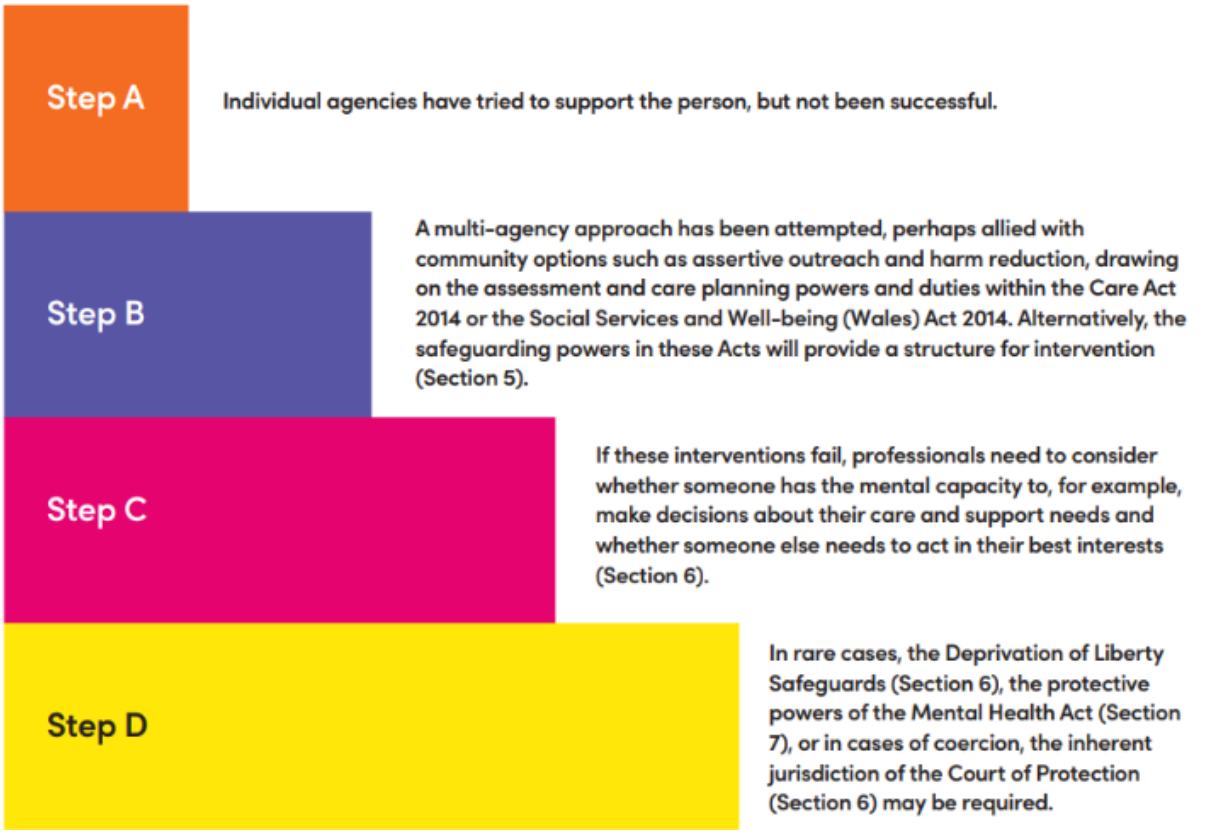
One of the key areas that needs to be challenged with practitioners is that alcohol dependence is a "lifestyle choice". The Latin word for addiction means "enslavement". When someone is enslaved their freewill and ability to make choices is taken away from them. It is also important to remember that unmanaged withdrawal from alcohol can be very dangerous and therefore to "just stop drinking" for someone who is alcohol dependent is not an option. In fact, it could potentially end their life.

Individuals with chronic dependency on alcohol are not always seen as having care and support needs because during the times when they are sober, they are able to care for themselves. Alcohol dependency is a chronic relapsing condition, and those who suffer from the condition may well have brief periods of sobriety. However, only relying on assessments completed at those times would not help the person at the times that they need it the most. For Sophie, due to her mental and physical health issues this was not a factor as she was deemed to have eligible care and support

needs. However, others may not have other needs which would lead them to be eligible for support under the Care Act.

There were no referrals made to the Safeguarding Team for Sophie in relation to self-neglect until the last few days of her life. Practitioners who encountered Sophie did not recognise her alcohol dependency as self-neglect. This is clear from the Individual Management Report responses to the question related to the Responding to Self-neglect in Shropshire Guidance. It cannot be known if the outcome for Sophie would have been different if her alcohol dependency had been seen as self-neglect earlier and managed through the lens of a safeguarding approach.

"How to use legal powers to safeguard highly dependent drinkers in England and Wales" identifies a four stepped approach to using legal powers. It notes that the final step should be used a very last resort and only in very rare circumstances.



For Sophie, individual agencies continued to try and support her and as discussed this was done with some liaison, but a multi-disciplinary meeting was never called. A recommendation has already been made about this. However, in addition to this, the practice check lists should be used by practitioners on pages 17 and 18 of the document. **We recommend that the practice checklists from pages 17 and 18 of "How to use legal powers to safeguard highly dependent drinkers in England and Wales" be ratified as practice tools for those working with dependent drinkers in Shropshire. Once ratified these documents should be added to the**

Shropshire Safeguarding Community Partnership website and an evaluation of their usefulness carried out in six months.

We also recommend the information relating to mental capacity assessments for those who are alcohol dependent, (in the evidence base section of this report) be added to a learning briefing and shared across the partnership. Agencies should provide evidence as to how they have used this briefing with their frontline practitioners.

The Blue Light Project Manual provides some useful tools for practitioners to use with a particular group of dependent drinkers. These are known as Blue Light clients and they account for about 400 people in a local authority area of approximately 350,000 people (according to the 2021 Census Shropshire had a population of 323,600 people). It is for each local area to define their Blue Light client group and this should be done by having criteria under the following three descriptors:

- **The alcohol problem** (the criteria could be the length of time the person been dependent on alcohol, Ethanol levels or biomarkers such as Liver Function scores, scores on assessment/audit tools being a certain amount or above)

- **A pattern of not engaging with or benefiting from alcohol treatment** (the criteria could be the person been referred to services and not attended appointments, they attended and then disengaged, they attended but not changed)

- **A burden on public services** (the criteria could be the person has had 5 hospital admissions in a certain period time, the person has been arrested whilst intoxicated 3 times in a certain period of time, the person is known to housing services due to not being able to maintain a tenancy because of their drinking)

Shropshire does not currently have a set of criteria to define Blue Light clients at present. They also do not use the practice tools within the manual. **We recommend the Shropshire Safeguarding Community Partnership's Drug and Alcohol Group, carry out a review of "The Blue Light Project Manual" and consider which, if any elements they feel would be appropriate to adopt in Shropshire.**

How the Adult Safeguarding and homelessness briefing: Positive Practice could be used to inform recommendations [Shropshire Council only]

Sophie had care and support needs as defined by the Care Act 2014. The local authority also had a duty to house her under the Housing Act 1996. Sophie was placed in temporary accommodation on 23.03.22. Sophie had just been discharged from hospital following a period of alcohol detoxification. The Shropshire Council Housing Options Team acknowledge that this initial placement was not ideal however this was what was available at the time. Sophie could have been placed in an out of

county bed and breakfast, many of which are also attached to or close to pubs or other licensed premises. Moving Sophie out of county would have left her even more vulnerable as it would have taken her further away from her support network.

When Sophie moved to alternative temporary accommodation on 19.04.22 it is noted by her family and professionals that this was a very settled time for her. It was deemed a more suitable option due to the distance from anywhere she could access alcohol, Sophie had her longest period of abstinence during this placement. Sophie was visited regularly by her housing support officer and full housing duty was accepted. Sophie was supported to make regular bids on properties that would be suitable for her needs. There were occasions when the hotel would notify the housing team that they needed Sophie's room as it had been booked. This meant that Sophie would have to leave for a couple of nights and be housed somewhere else before moving back to the Hotel. Sophie was able to stay with her dad and step mum for short periods. Her parents said that others were not so lucky and would have to go to other bed and breakfasts. This was unsettling for everyone.

When Sophie moved to another temporary accommodation placement in Shrewsbury town centre there was a significant increase in her alcohol use. Whilst she was not able to drink in the onsite bar, she was in Shrewsbury town centre and had access to alcohol. During this time Sophie was offered a property. Her family say that Sophie felt obliged to accept the property and whilst it was a bungalow with a wet room it was in a poor state of repair. Sophie and her family were reassured that these things would be taken care of prior to her moving in however they felt they were required to still do a lot of the work themselves. The family met with the housing provider following Sophie's death and there was agreement that some of the levels of cleanliness could have been improved prior to Sophie moving in however, a fit for let inspection had been completed and the property did meet this standard.

Adult Social Care identified the need to make a referral to the Occupational Therapy team who would have assessed what Sophie needed in her own environment to help meet her eligible needs, however this was not done.

Shropshire Council's Housing Options Team are working on expanding their temporary accommodation supply. It is recognised that the current offer is not adequate, and a hotel room is an unsuitable option. Currently there are limited places within the county that will accept individuals on a temporary basis and often these placements are attached or linked to establishments serving alcohol. Due to the lack of options placements can be made out of county, the implications of sending people out of the local authority area are vast and this is why they are working hard to increase the supply in county.

The recommendations already made in this review relate predominantly to multi-agency working, mental capacity, the use of the Responding to Self-neglect and Working with Risk documents and legal literacy. We will therefore not make any additional ones. However, it is suggested that practitioners should be mindful of

having conversations with individuals who are preparing to move into social housing properties about their expectations of what 'fit to let' means.

7. CONCLUSION

Sophie is a much-missed daughter and family member whose death is keenly felt by those who loved her. It is important that all agencies learn from her death and from the experience of her family who fought hard to get the right support for their daughter.

The last twelve months of Sophie's life was dominated by an addiction that she struggled to manage and there is no doubt that there were serious concerns regarding her health and wellbeing voiced by practitioners at various times often with one another.

Her family called multiple agencies and asked for help for their daughter. For professionals working with individuals like Sophie with such complex needs, it is not easy to find the right solution. There was evidence that agencies actively tried to share information with one another. The difficulty was that no one agency took the lead in coordinating a response so that there could be multi-agency assessment of risk and plan put in place to support Sophie and her family.

There were individual practitioners who built very strong relationships with Sophie over the time they worked with her, and we would like to acknowledge their efforts. Many professionals have spoken movingly about the loss of Sophie.

This review has shown that opportunities were missed by professionals to:

- Understand the connection between the physical pain Sophie experienced and its links to her alcohol misuse;
- Utilise local and national guidance to inform practice;
- Work with Sophie in person in order to form a better connection with her;
- Convene multi-agency meetings to:
    - Identify a lead agency
    - Identify a lead professional
    - Formulate a multi-agency support plan for Sophie
    - Assess, support and share information with Sophie's parents

Our thanks go to Sophie's family for sharing their views and concerns about Sophie and for their effort to try and get the right support in place for her. Our thanks too, go the organisations that have contributed to this review process.

8. RECOMMENDATIONS

Recommendation 1 - We recommend that this local protocol, regarding onward referrals for support and safeguarding, should be reviewed to ensure that it is fit for purpose and meets the needs of adults with care and support needs in Shropshire.

Recommendation 2 - We recommend that when agencies are working with individuals who drink alcohol to excess, they should where possible ask questions to enquire where the individual is sourcing the alcohol. If these enquiries identify a licensed premises, then the Licensing team should be contacted and informed of this.

Recommendation 3 - We recommend that the Licensing Team visit the shop where Sophie is known to have made some of her purchases and speak with them about this review and the potential implications of the sale of alcohol to people who appear to be intoxicated.

Recommendation 4 - We recommend that the Licensing Team ensure that licensees are reminded of their responsibilities under Section 141 of the Licensing Act 2003 when they are sent their annual fee reminder email**.**

Recommendation 5 - To complement the existing learning briefing about carers, we recommend that a short video on how to recognise individuals with caring responsibilities and how to access appropriate support be created and hosted on YouTube.

Recommendation 6 - We recommend that there is a clear plan for launching the new version of the Self-Neglect Guidance. Each agency should demonstrate to the partnership how they are going to embed the guidance within their organisation and take responsibility for having a rolling programme of learning for new practitioners.

Recommendation 7 - We recommend that a short video on convening multi-disciplinary meetings is created and shared widely across the partnership.

Recommendation 8 - We recommend that a learning briefing on S13(4) be developed and sent out across the partnership to aid understanding and help professionals to support families who care for loved ones with mental health issues. Agencies will need to demonstrate how they have used this with frontline professionals.

Recommendation 9 - We recommend that the partnerships strategic leaders agree that when any one of them are planning the implementation of a policy such as the

Most Appropriate Agency, they allow time for consultation with other partners. This will support all agencies to ensure that they update their policies and prepare frontline staff for these changes.

Recommendation 10 - We recommend that the practice checklists from pages 16 and 17 of “How to use legal powers to safeguard highly dependent drinkers in England and Wales” be ratified as practice tools for those working with dependent drinkers in Shropshire. Once ratified these documents should be added to the Shropshire Safeguarding Community Partnership website and an evaluation of their usefulness carried out in six months.

Recommendation 11 - We also recommend the information relating to mental capacity assessments for those who are alcohol dependent, (in the evidence base section of this report) be added to a learning briefing and shared across the partnership. Agencies should provide evidence as to how they have used this briefing with their frontline practitioners.

Recommendation 12 - We recommend the Shropshire Safeguarding Community Partnership’s Drug and Alcohol Group, carry out a review of **"The Blue Light Project Manual”** and consider which, if any elements they feel would be appropriate to adopt in Shropshire.

At the time of publication work has begun in implementing the above recommendations

REFERENCES

i responding-to-self-neglect-in-shropshire.pdf (shropshiresafeguardingcommunitypartnership.co.uk)

ii How to use legal powers to safeguard highly vulnerable dependent drinkers | Alcohol Change UK

iii The Blue Light approach | Alcohol Change UK

iv Adult safeguarding and homelessness: a briefing on positive practice | Local Government Association

v UK Chief Medical Officers' Low Risk Drinking Guidelines (publishing.service.gov.uk)

vi Part 3: Drinking alcohol - NHS Digital

vii Self neglect guidance July 2023 (homelesshealthnetwork.net)

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

ix ACUK_SafeguardingAdultReviews_A4Report_July2019_36pp_WEB-July-2019.pdf

x Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)

xi Safeguarding-guide-final-August-2021.pdf

xii Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 | Local Government Association

xiii Self neglect guidance July 2023 (homelesshealthnetwork.net)

xiv Trauma-informed approaches to supporting people experiencing multiple disadvantage (publishing.service.gov.uk)

xv analgesics-chronic-pain.pdf (bma.org.uk)

xvi Using Alcohol to Relieve Your Pain: What Are the Risks? | National Institute on Alcohol Abuse and Alcoholism (NIAAA) (nih.gov)

xvii About thiamine - NHS (www.nhs.uk)

xviii Alcohol misuse - Treatment - NHS (www.nhs.uk)