

Wiltshire Safeguarding Adults Board

Learning Briefing Safeguarding Adults Review - Adult D

Our review

This briefing outlines key themes and recommendations from a review carried out in August 2018. The Care Act 2014 states that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of, or is thought to have suffered, abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The purpose of the SAR is to promote effective learning and improve action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and the way agencies work together improved. The purpose is not to re-investigate an incident, nor is it to apportion blame - other processes exist for such investigations, including criminal proceedings and disciplinary procedures.

The methodology used for this review was our own Local Learning Review (LLR) process. Each organisation completed a report for the Board and these, along with other relevant information, were considered at a desktop review session. That session was attended by those agencies and chaired by the Independent Chair of the WSAB. The Deputy Chair was the Director of Adult Care Operations at Wiltshire Council, an agency Adult D had no contact with. This report has been produced to capture that discussion and to share findings.

We encourage all those working with vulnerable adults to read this briefing, and reflect on how you can challenge your own thinking and practice in order to protect vulnerable adults in the best way possible.

This document includes a feedback sheet to capture how you have used this learning. This should be completed and returned to LSAB@wiltshire.gov.uk

Adult D

Adult D was 40 years old. He was of no fixed abode but is understood to have been living with a relative in Somerset.

We know that Adult D had presented to a Hospital Emergency Department in the South of England in early 2017, reporting symptoms of alcohol withdrawal. He was advised to continue drinking on discharge, to avoid withdrawal, until he could access support.

A few days later whilst travelling through Wiltshire, Adult D was asked to leave a train when it stopped at a local station after he was found to be heavily intoxicated and unable to produce a ticket.

In the early hours of the following morning, police were called to a nearby block of flats where Adult D had gained access to a communal area. Officers had difficulty communicating with Adult D, who appeared to speak little English.

A local resident called 999 and police staff attended. On finding Adult D to be heavily intoxicated, officers called an ambulance and paramedics attended. Physical checks were not carried out by the paramedics and Adult D was not taken to hospital. Adult D was left with police officers who then took Adult D to a local public toilet block, in which they believed he had indicated he was content to shelter overnight. Adult D was found, deceased, the following morning in the toilet block.

A Coroner's Inquest found that Adult D's death was caused by acute alcohol intoxication and hypothermia.

Adult D's family were contacted before this review took place but have not been involved in the review process.

Other reviews

Following Adult D's death, the coroner carried out an Inquest and completed a Regulation 28 Report to Prevent Future Deaths. Adult D's death was found to be an accident, contributed to by neglect.

An Independent Office for Police Conduct investigation has taken place and the Assistant Chief Constable has issued a response to the Regulation 28 Report outlining how the force will respond.

The ambulance service undertook an internal investigation and the Trust have reviewed the advice provided to staff about the assessment of patients who are intoxicated and the availability of translation services.

Both the police and ambulance services have reviewed the actions of, and provided training to, those officers involved.

Key Themes and Learning Points

What were the risks to Adult D?

Both police and ambulance staff acknowledge that there were obvious, and some less obvious, risks to Adult D and that those risks were not well assessed or dealt with. From the outset, professionals failed to communicate effectively and, as a consequence, the overall response was flawed.

Adult D had a history of complex needs including alcohol dependency. He had been seen on a number of occasions by police forces in other areas and by the ambulance services, and his records indicated poor mental health. This information was available to those in the police control rooms but wasn't effectively communicated to the officers who were with Adult D.

In addition to his mental health and history of alcohol dependency, there were clear risks to Adult D on the night he was seen by police and ambulance staff in Wiltshire. It was a cold winter night and Adult D was in a pool of his own urine. He was highly intoxicated and did not have access to, or means to get to, any accommodation.

Partners attending the review talked about the high number of incidents they are called to involving very intoxicated individuals, some of whom may be seen regularly in this state. In these situations, there can be a tendency, as this case shows, to "pre-judge" these individuals, thinking that they "have complex needs that cannot be resolved in a single episode of contact". This means the alcohol dependency is viewed in the context of a condition with long-term health risks. In the case of Adult D, this judgement may have prevented staff seeing that, in this instance, intoxication was presenting an immediate threat to the individual's health as well as a longer-term risk.

What happened to Adult D suggests a cultural issue in our treatment of adults who present as highly intoxicated. Police officers were quick to deal with the possibility of anti-social behaviour and an ambulance arrived at the scene. Both agencies reported that they frequently see people who are highly intoxicated, not all of those individuals are, or need to be, conveyed to a police station or to a hospital. However, in this case it appears that assumptions were made about Adult D's situation that lead professionals to overlook the need for a formal risk assessment to protect Adult D from further harm.

Learning:

- **Emergency services staff should proactively consider the clear links between alcoholism and mental health when treating someone who is highly intoxicated, and how this may impact upon their safety at that moment. Mental capacity should always be a consideration when an adult is known, or appears, to be alcohol dependent.**
- **The risk posed by those who are highly intoxicated needs to be assessed with reference to the impact that intoxication will have on their mental and physical ability to protect themselves from harm.**
- **Those who are known to be regularly intoxicated should not be considered less at risk simply because they are known to be alcohol dependent.**

What measures were put in place to reduce the risks to Adult D?

Professionals who attended the review agree that Adult D should have been taken to hospital. The assessment undertaken by ambulance staff was cursory and a physical assessment was not undertaken. Adult D asked to be taken to hospital and indicated that he was an alcoholic - he felt he needed medical help.

Furthermore, no record was made of the incident by ambulance staff. Decision-making in an emergency situation can be weakened by a failure to record decisions. A written record not only shows why a particular decision is being made, it provides an opportunity to document an account of the decision-making process which can be referred to should that decision be questioned in the future. Creating a written record therefore has potential to protect both the patient and the practitioner.

However, there are other mitigating actions which could have reduced the risks to Adult D posed by the low temperature and his physical vulnerabilities that night.

Information about where Adult D was living reflects a confused picture. Whilst some of the reports received by the Board identify that he was of no fixed address, it is clear that professionals with Adult D on the night of his death were aware that he was staying at an address in Somerset but considered that "getting him home was too far". Other reports suggest that the address in Somerset was not recorded on the police system.

It is acknowledged by all parties that Adult D said he wanted to be taken to hospital. However, in hindsight, the ambulance service have concluded that staff believed the incident was "police-led" and that accommodation for Adult D was being sought by the police. Police officers did consider several options including: arresting Adult D (who was in possession of goods with security tags intact) and seeking either hotel accommodation or a homeless shelter (supported accommodation).

Adult D could have been arrested on the basis that he was in possession of stolen goods or under Section 136 of the Mental Health Act 1983. It is unlikely that in the early hours of morning and given the condition Adult D was in that, even if he had funds, a hotel would have provided him with accommodation. The review found that no emergency supported accommodation is available in the area and Wiltshire Council confirmed that any such accommodation would have been unable to offer shelter because of the risk Adult D may have posed to other vulnerable adults.

Police officers sought help for Adult D by calling for medical assistance. Having attended, ambulance staff were of the view it was a social, not a medical, issue and that the police should seek to reduce any risk to Adult D.

Learning:

- **Professionals from any agency treating those in crisis should, as part of their risk assessment, consider the wishes of the person at risk of harm. Despite the language difficulties, Adult D stated he was an "alcoholic" and that he wanted to be taken to hospital.**

- **Neither supported housing provision or detox facilities in Wiltshire offer emergency admission. In addition, supported accommodation would not provide the right level of support to accommodate those in need of emergency medical care and would not accommodate those who may pose a risk to other residents.**
- **Practitioners from all agencies should work to effectively safeguard a vulnerable adult who poses risk to themselves and/or to others in an emergency situation by discussing and agreeing, as a collective, how the adult's immediate needs will be met. That decision should be understood and recorded by all agencies.**

“Professionals need to see the person not the problem.... I would have liked officers not to have left [Adult D] until there was a solution.” (Wiltshire Police)

What training had staff received to help them protect and support Adult D?

Both ambulance and police officers are trained to assess risk in emergency situations. Their training helps them to assess whether an arrest should be made and when a person should be taken to hospital. What happened in this case highlights what can happen when both services feel someone “does not quite meet the criteria” for arrest or hospitalisation. This case underlines a perceived “gap” between the services of the police and of health services.

In this case, the assumptions professionals made, the time of night, the pressures on the staff attending and the language barrier, all appear to have impacted on the ability of trained staff to effectively protect Adult D.

A representative from the local hospital was unable to join the review session however subsequent discussions with the team have taken place. On review of the case, the view is that staff would have “taken into consideration all of the factors” and “the balance of probability is that [Adult D] would have been kept in a short stay ward overnight to sober up” and “possibly seen by mental health team in the morning”. However, it should be noted that “the hospital was also under intense pressure and so every bed and admission would have been reviewed”. The decision to admit Adult D would have depended on the information provided by ambulance staff about Adult D’s wider vulnerabilities.

Discussion of what training was provided also revealed that a protocol was in place between the police, ambulance service and local hospitals, to help professionals assess the health of people who are drunk and in need of medical assistance. None of the senior professionals involved in the review were aware of the protocol, and neither were the frontline practitioners who met Adult D.

Learning:

- **The most well-made protocol will not improve outcomes without helping professionals to understand it and being able to implement it. The high frequency of emergency services being called out to incidents involving drunk persons has been highlighted by this review. A new protocol around managing the risks associated with this should be agreed by emergency services agencies and local hospitals, and plans to implement that protocol shared with the WSAB.**

- Managers should emphasise that keeping a vulnerable adult safe in an emergency situation always outweighs the need to evidence how criteria for arrest or hospitalisation have been met. If risk to life is assessed as high, the need for care is always more important than the criteria for care.



Key Themes and Learning Points

Good practice

Whilst this review largely focuses on what needs to be changed it should also be noted that:

- Both the police and an ambulance attended, with the intention of assessing Adult D and what action should be taken. The call was given priority status by the police.
- Police officers attempted to communicate with Adult D by using phone-based language services to overcome the language barrier.
- Control rooms did have information to identify Adult D as a particularly vulnerable adult.
- Since the death of Adult D, services have sought to improve how they work to prevent future harm, including taking part in this review.

Challenges for the partnership

Wiltshire Safeguarding Adults Board brings together key partners who are collectively responsible for safeguarding adults in Wiltshire, under the Care Act 2014. The most important function of the Board is to improve the way that services work together to protect adults at risk. Single agency actions have been addressed through the reviews referenced above and concerns relating to policy set nationally have been raised by the Coroner. This review seeks then to identify specific points of action and learning for local partners, to improve the way they work together:

- Alcohol-dependent adults are particularly vulnerable and are frequently seen by emergency services, however in the event that Adult D had been taken to a hospital, there is no certainty he would have been admitted and, if he had been taken to a police station, no medical assistance would have been immediately available. Resource limitations may make the creation of a specialist resource to support adults in this situation untenable, therefore the system needs to mitigate risk by agreeing a multi-agency protocol and using existing powers and resources to ensure that adults at risk are protected to ensure we prevent the same thing happening again. **A multi-agency protocol should be established to support professionals who are called to attend adults at risk who are highly intoxicated and who pose a risk to themselves and, potentially, to others.** This will support professionals to make the right decisions to protect adults from risk.

- Effective 'out of hours' multi-agency work appears to have been prevented by an attitude which prioritised reducing pressures on over-stretched resources over the care of an adult at risk. The view of ambulance staff was that Adult D would not be admitted to hospital even if he was taken to the Emergency Department whilst, for police, the closest custody suite was a 45-minute drive away. These concerns were potentially aggravated by the belief of ambulance staff that police would find shelter for Adult D, alongside the police officers' misapprehension that, having called ambulance staff to attend, they had taken sufficient measures to protect Adult D's health. **When staff from more than one agency are involved in a crisis situation, a formal risk assessment must be carried out and decisions about what actions should be taken agreed and recorded.**
- In this situation, no safeguarding referral was made despite two agencies coming into contact with an alcohol-dependent, vulnerable adult who was of no fixed address, who was unable to access shelter and who was at increased risk in cold weather. Should emergency services attend an individual who is in this situation, **a safeguarding referral must be made.**
- The language barrier has been highlighted by both agencies and clearly caused an additional difficulty to professionals trying to communicate with Adult D. All frontline staff should be aware of, and have easy access to, translation services. **Agencies should be clear about the hours of operation for these translation services, and the translation services should provide an effective out of hours provision.**
- In spite of communication issues, professionals should be able to effectively assess risk using the information available - visually, from what verbal communication there is, from information held by control rooms, from physical evidence and having assessed the environmental conditions. **The Board should assess the need for multi-agency training on safeguarding vulnerable adults who are in crisis owing to alcohol dependency or mental health breakdown, to ensure that any new protocol is embedded into practice.**
- The Board sought to involve the train operating company in this review in order to consider their role in safeguarding individuals who are in transit. **The Board should write to the train operating company and to British Transport Police to seek assurance that service provision is sought as necessary to reduce risk to vulnerable adults.**

Feedback

To further help us share this learning, please complete the short form below and send back to us at Isab@wiltshire.gov.uk.

Name	Date
Job title	
Agency	
Who was this briefing cascaded to (e.g. District Nurses, Social Workers)?	
Where was this briefing used (e.g. 1:1/group supervision, team meeting, training event with X number of staff)?	
Changes to your organisation's practice following the learning:	
1.	
2.	
3.	
4.	
5.	
Other feedback:	