Gateshead Safeguarding Adult Board

Safeguarding Adult Review – Thomas

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January 2024

Contents

1. Introduction

Thomas was a 41 year old white British male who was found dead at his home in February 2021. He had been released from prison in January 2020 after a 10 year Prison sentence. He returned to Prison on remand in December 2020 and died six days after having been released again.

Police had forced entry into his property due to a breach in bail conditions. Evidence of drug taking (i.e. medication blister packs) was found next to his body and he had two psychoactive drugs, Flubromazolam and Buprenorphine, in his system at death. Police Officers found no reason to believe there was any third party involvement. At the request of Thomas's family the inquest into his death was closed in June 2021. The coroner recorded his death as "drug related".

Adult Social Care referred Thomas for a Safeguarding Ault Review (SAR) under section 44 of the Care Act due to concerns about how partners worked together to support him prior to his death. The SAR Complex Cases group (SARCC) agreed this and determined that the SAR would explore the period following his release from prison in January 2020 until his death.

2. Purpose of a SAR

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

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults.
- To review the effectiveness of procedures both multi-agency and those of individual agencies.
- To inform and improve local inter-agency practice.
- To improve practice by acting on learning (developing best practice).
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

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

3. Independent Review

Mike Ward was commissioned to write the overview report. He has been the author of fourteen SARs as well as drug and alcohol death reviews and a member of a mental health homicide inquiry team. He worked in Adult Social Care for many years but in

the last decade has worked mainly on developing responses to change resistant dependent drinkers.

4. Methodology

A multi-agency panel of the Gateshead Safeguarding Adult Board was set up to oversee the SAR. Initial information was sought from agencies involved with Thomas using the SAB's Individual Management Report Form. This seeks information on the individual, a chronology and an analysis of agency involvement.

Some of the information provided was from outside the time period identified, enabling a fuller picture of Thomas to be developed.

The following agencies were involved in the process:

- Newcastle upon Tyne Hospitals NHS Foundation Trust (limited engagement)
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- North East Ambulance Service
- HM Prison Service
- Probation Service North-East
- Adult Social Care
- The Community Hub
- OASIS Housing
- Northumbria Police
- Gateshead Health NHS Foundation Trust
- Gateshead Recovery (Substance Misuse Services)

All of the information provided was analysed by the author and an initial draft of this report was produced and went to the Review Panel in August 2023. Further changes were made over the next two months, and a final draft was completed in October 2023.

5. Family contact

An important element of any SAR process is contact with family. Thomas was the eldest of five siblings; however, contact has only been had with a sister who supplied some useful background information about him. She was asked to contribute further to the process but did not feel able to provide input.

6. Parallel processes

There were no parallel processes such as Police or Coronial inquiries that coincided with the review process.

7. Background and personal Information

Thomas was a White British male who died at the age of 41. He was the eldest of five siblings and grew up and lived his life in and around Gateshead. He also had wider family, some of whom lived in Scotland.

He didn't engage well at school and was recorded as leaving mainstream education at 15 without qualification. He had no subsequent employment history. His sister described Thomas as someone who enjoyed cycling, playing football and supported Newcastle United: *"a typical young lad often up to mischief."* As an adult, Thomas would talk about how much he liked visiting Scotland. He also wanted to get a passport and travel abroad when *"things settled down for him"*.

His parents appear to have separated and his mother is referred to infrequently in agency notes. In the later years of his life he was estranged from his family, and had no significant contact with them. It is reported that, on one occasion, he had assaulted his father and an aunt and uncle. However, none of these wished to pursue charges despite their injuries being noted on body worn Police cameras. Thomas is said to have called his father a "nonce" and said he was going to produce a documentary about him; this was dealt with by the Police. However, his father visited him frequently following his remand in custody prior to sentence but visits tapered off as the 10 year sentence progressed.

Thomas had a long history of involvement with the Criminal Justice System. There are 34 entries for him in Police records for the review period alone. He was arrested a total of 89 times between 1995 and 2020 including offences against the person, public order, breach of bail, acquisitive crime, drugs, traffic offences and criminal damage. There are also 27 pages of warnings about Thomas in the Police records, going back to 2004 including for weapons, violence and domestic violence. Within the review period there were warnings for officers to visit him double crewed. He was known to have concealed a kitchen knife and screwdriver in his waist band. He was also reported as a victim in eight crimes during 2020. He had a history of poor compliance with sanctions imposed.

Probation notes highlight Thomas's involvement in four adult intimate relationships prior to 2010: some involving alleged domestic abuse by Thomas and consequent Police call outs. In the period from 2005 Thomas was in a relationship with J. It is not clear when this relationship ended but there are 13 domestic violence reports concerning her between 2005 and 2010. J is said to have sustained, at various points, a broken nose, black eyes, and a punctured lung from Thomas. This violence was often exacerbated by his excessive alcohol consumption. J already had one child (now aged 17), and Thomas had a child with her (now aged 14). In 2005 he was remanded in Prison as he awaited trial for an assault against J whilst she was pregnant with his child.

Both children were placed on the child protection register in 2008 under the category of emotional abuse. Thomas was not allowed any unsupervised access to them. He had regular contact with his daughter at weekends and this seemed to work well, however, there was ongoing domestic violence between Thomas and J which affected

his contact with the children. Throughout his sentence from 2010 onwards, a constant theme was Thomas's anger towards J, whom he blamed for his baby daughter's removal, insisting he would always pursue contact with the child.

In 2008 – 2009 he was issued with a Community Domestic Violence Programme (a Probation Order). These were discontinued in 2013 but they offered a community delivered programme aimed at reducing the risk of domestic violence and abusive behaviour towards women in relationships by helping male perpetrators change their attitudes and behaviour and reduce the risk of all violent and abusive behaviour in the family.

However, the violence seems to have continued and in 2010 he received a seven year prison sentence for a Section 18 assault.[1] He came out in 2013, but immediately breached his bail conditions and was assessed as a serious risk to his ex-partner; he was returned to Prison and was not released again until January 2020.

In custody, he obtained qualifications in construction, gardening, painting, and industrial cleaning and undertook literacy and numeracy on a one to one basis in 2011; stating the motivation to engage in education was to benefit his future.

During the latter years of Thomas's incarceration, it was reported that he had found God and was a 'believer', with intense bursts of focus on religion. It is suggested by the Probation Service that he was following the Christian faith although this is not confirmed. In 2018 he informed his Supervising Officer at the time that Muslim prisoners were *'trying to corrupt his faith'*, whilst also referring to the Pope as a paedophile. It is reported that he continued to talk about religious belief when released into the community.

In the last thirteen months of his life, following his release, Thomas lived alone, he was unemployed and appeared to have had no contact with his children. On release, Thomas lived in temporary accommodation and then held a tenancy on a one bedroom, ground floor flat with Gateshead Council until his death.

During this period he was in custody twice. He was recalled to custody on 20/1/20 and was released again on 23/3/20. In December 2020, Thomas was remanded in custody for breaching a restraining order. He was released on 4/2/21: 13 days before his death. In November 2020 he was also detained under Section 2 of the Mental Health Act. Following this, despite having a tenancy, a continued belief that he was being persecuted resulted in him sleeping rough until he was placed back on remand.

The last thirteen months of his life are characterised by three main things which are described in more detail in later sections of this review:

- Substance use
- Deteriorating mental health
- Increasingly poor self-care and home environment.

[1] Grievous bodily harm and wounding are covered in sections 18 and 20 of the Offences Against the Person Act 1861. Sections 18 and 20 carry different maximum sentences, with section 18 being the considerably more serious of the two.

Throughout the review period Thomas was placing a repeated impact on public services, in particular the Ambulance Service and the Police. The Ambulance Service IMR highlights that there were so many calls that they do not document them all. However, in just September to November 2020 there were 58 calls. Most of these were made to 111/999 by Thomas himself. There were often several calls placed within a short period of time, then there would be gaps when Thomas did not call. In October 2020, a year's restraining order was imposed because of the calls he was making when there was not a genuine emergency. Thomas also attended the local A&E on a total of 18 occasions for complaints in relation to pain management and his mental health.

In the second half of 2020, Thomas had considerable contact with his local Community Hub. This was a temporary service supporting the Council's Covid response. The Hub offered food, advice, telephones and acted as an advocate for Thomas to access multiple services. This service was well placed to observe the decline in Thomas over the last six months of the year. For example in November 2020, they recorded that: *Thomas rings almost every day now with various challenges…We seem to be the most effective tool for sorting out his needs. Last week we sorted out his locks as he lost his keys...His TV seems to have been smashed…And he has returned his furniture pack as it was not up to scratch.* On another occasion they record that: *engagement with Thomas was like watching someone age and die before our eyes and being powerless to intervene.*

His contact with services was also very challenging. He appeared to experience paranoid delusions and was extremely mistrustful of services: *ultimately believing they were responsible for a number of unfortunate events in his life.*

In particular he threatened staff. The Ambulance Service had flags on their system due to verbal abuse and intimidating behaviour. More significantly, he was arrested for threatening a female member of staff at the Drug and Alcohol Service. He became angry at being unable to access a mobile phone and threatened her by saying *"I'm going to slash your pretty little face open when you finish work"*. Thomas then refused to leave the service until Police arrived. The worker was appropriately pressing charges for this incident.

As a result of other threatening behaviour, Thomas was barred from three pharmacies in Gateshead as well as his GP surgery (he was placed under the Special Allocation Scheme – for difficult to manage patients). These concerns were reinforced by suggestions that he had access to a weapon (recorded by the Ambulance Service in September 2020). Thomas could also present as agitated and verbally aggressive and threatening towards staff when he attended Hospital.

In September 2020, as a result of the risk he posed, a referral was made for him to come under MAPPA (multi-agency public protection arrangements). This referral was not accepted. The MAPPA referral panel felt that although he had displayed aggression and mental health issues, this had been the case for some time, and he did not appear to be presenting any different risks. They suggested the referrer speak with Adult Social Care about further care.

In April 2020, he had a telephone consultation with his GP which provided a powerful example of the problems he posed: *"A long rant / monologue by the patient who wants scans and X-rays on his back. Aggressive and demanding tone. Appears not to listen at all and allows few interruptions to his monologue. Says he has been denied his human rights and has a human rights solicitor. The (Prison doctor) has sent me "forms" stating all about his medical problems and he wants these forms from me. He believes he needs a neurosurgeon… It was hard to communicate at all with him. Much of his monologue was irrelevant vaguely threatening and demanding without it being clear what action he wanted. He did not respond to attempts to find out what his symptoms are."*

In the Special Allocation Scheme this pattern continued. In a telephone call to the GP, Thomas: *"Went on ranting…That I was part of some conspiracy…I proceeded to explain why he was registered here on his request but was met by his ranting and I could not get a single word through. I had to hang up as his ranting was getting abusive. I called 111 to stop him from taking advantage of the system and apparently he had called them 5 times already."*

On the other hand, he could also be difficult to engage. For example, he was referred to a housing provider for resettlement support in April 2020 but did not respond to any attempts to contact him. Primary Care also commented on his unwillingness to engage with Mental Health Services.

There is some evidence that Thomas felt himself to be at risk from others e.g. local drug dealers. He had concerns about being seen as a paedophile and made a number of reports about threats of violence towards himself including by Police Officers. For example, in December 2020, Thomas attended A&E in Newcastle due to an earlier ankle injury sustained, he claimed, because he had been abducted from a forecourt, taken to the River Tyne where two men attempted to drown him. He separately attributed this incident to Police Officers. One IMR said that Thomas always felt unsafe and all he wanted was to feel safe.

In December 2020, Thomas took an overdose and was found unresponsive, he was transported to Hospital. In February 2021 Thomas was found deceased by Police Officers, with empty blister packs around him.

8. Understanding Thomas's presentation

Given Thomas's repeated pattern of aggression, self-neglect and service refusal, it was important to understand what lay behind this challenging presentation. It would be easy for professionals to see this behaviour as simply the result of substance misuse and to close the case when he failed to engage. However, professional curiosity would suggest that there was far more to Thomas's behaviour.[2]

Four main drivers may have underpinned his complex behaviour:

[2] This can be called *diagnostic overshadowing* – where everything gets blamed on the drugs or alcohol.

- Substance use disorders
- Mental disorders
- Anti-social personality disorder
- Cognitive damage

In addition, it is possible to speculate that use of the new psychoactive substance, spice, could have been a factor. This section explores these in turn but then the review looks beyond these to the possible responses to such a complex presentation.

8.1 Substance use disorders

For much of the period under review Thomas was on a Buprenorphine script from the local Drug and Alcohol Service. Buprenorphine is an opiate substitute given to heroin users as a safer alternative to street drugs. Therefore, at first sight it is easy to assume that Thomas is a man with a history of heroin use. However, the picture is far more complex.

Prior to 2010 and the start of his long prison sentence, the Probation Service report that Thomas had issues with alcohol and drugs and did engage periodically with relevant services. However, the main substance he used appeared to be alcohol. Much of the domestic abuse he perpetrated was reported to be associated with intoxication. In prison, he started taking prescribed methadone. This is again usually a heroin substitute but in his case appears to have been used as a pain killer to deal with back pain. No evidence is reported of other substance misuse in prison.

On moving back into the community he is transferred onto a methadone script from the Drug and Alcohol Service and then in March 2020, at his request, he moves on to a Buprenorphine script. However, the dose he receives is at the bottom of the range for this drug. He also expresses an interest in coming off the drug in a planned way: although this never happens.

He is drug tested by the Drug and Alcohol Service on at least three occasions (January, March and October 2020) and he is never positive for common illicit drugs – it is buprenorphine, methadone or benzodiazepines. Moreover at his death he has only Flubromazolam and Buprenorphine in his system. The former is a highly potent benzodiazepine which is only available in an illicitly manufactured form. (It is unclear where Thomas accessed this drug, professionals in the Practitioners' Workshop were not aware of it being commonly available locally.)

There is mention of alcohol use during this period. The Police reported holding information to suggest Thomas drank excessively. For example, in May 2020 Police Officers: *noted Thomas was drinking alcohol as there were vodka bottles around the living room.* In June 2020, an Officer described Thomas as seeming to be: *heavily under the influence of drink/drugs*.

However, there was no sign of alcohol dependence and no regular indications that alcohol was a problem. Thomas himself denied drinking alcohol.

His main interest appeared to be accessing prescribed psychoactive substances such as gabapentin. At points, e.g. June 2020, he was being prescribed Gabapentin by

his GP. However this was not continuous and on a number of occasions he was asking medical services, particularly Primary Care, for psychoactive substances.

- His GP reported five consultations with requests for prescribing in one month in April to May 2020.
- On 26/8/2020 there were five attempts to call and ask the GP to prescribe 200 tabs of dihydrocodeine *"To which I said no. Started calling me names which I don't think should be in an NHS record and at this moment I hung up"*
- In November 2020, he reported losing his prescription on the metro – he tried to access medication through 111 and the GP out of hours service. Two capsules of gabapentin and one mirtazapine were re-prescribed.

Thomas clearly had a pattern of substance use disorders. However, the nature of that problem is far from clear and there are indications that this problem was less severe than some people may have assumed.

8.2 Mental disorders

At the heart of Thomas's presentation is a debate about whether he had a mental disorder. As far as is known he did not have a history of mental illness before his ten year period in Prison. However, in Prison, Thomas continuously expressed the view, that prison staff were attempting to murder him and other inmates were making allegations against him. During his period in custody, he acquired numerous adjudications for behavioural issues, jumping on wing netting, abusive behaviour towards staff and on occasion was placed in segregation.

On release from custody in 2020, Thomas was assessed by Probation as reckless, characterised by denial and minimisation with little evidence of victim empathy or personal insight. Significant thinking deficits were referenced impacting his behaviour and it is stated he exhibited poor inter-personal skills often interrupting conversations, speaking in an aggressive tone, reacting impulsively to situations with volatility and that he could be threatening to staff.

During the review period, many services experienced him as having symptoms of a paranoid mental disorder. The Housing Service IMR described Thomas as very angry at the Council, Social Services, and the Police stating that they were in a conspiracy to kill him and that they were all murderers. He believed that food parcels were poisoned and that he wanted to *"cave their heads in"*. The Police IMR commented that: *information sharing …suggest(ed) Thomas suffered with his mental health…and quite often presented to officers as paranoid, he believed everyone was conspiring against him and wished to put him in jail for life or kill him.*

Mental Health Services did not share that view. The Trust IMR provides a picture of their engagement with him.

- Thomas first became known to the Mental Health Trust in January 2020. He was assessed by the Liaison and Diversion service in a Police Station. Thomas was assessed as not in a mental health crisis and that his issues were associated with substance misuse.

- In June 2020 Thomas was again referred to Liaison and Diversion due to bizarre behaviour while in custody…He was assessed as not being in mental health crisis and that his issues were associated with substance misuse.
- In September 2020 Thomas presented at Hospital displaying odd behaviours following a head injury. He was referred to the Psychiatric Liaison Team for assessment but declined to engage fully in assessment, stating that he wanted medication and a scan for his head. The assessment did not identify an acute major mental illness nor any suicidal ideation.
- On the 26th November 2020 Thomas was referred to the Crisis Team by an Inspector from the Care Quality Commission who had been investigating a complaint that he might have been kidnapped by Ambulance and poisoned with Covid-19. He was triaged by the Crisis Team and the findings revealed that he was presenting with delusional beliefs and a thought disorder. A Mental Health Act Assessment was organised.
- He was assessed under the Mental Health Act on the 28th November 2020 and was detained under Section 2. He presented with features suggestive of a psychotic illness. This was characterised by persecutory delusions relating to Police, Ambulance Services and people in authority.
- On the 7th December 2020, during his admission under Section, he was reviewed by a Psychiatrist who felt that he still presented with features of psychotic illness.
- On the 15th December 2020 he was reviewed by a Psychiatrist and findings revealed no evidence of acute psychopathology but there was evidence of anti-social personality traits. The Section 2 was rescinded and he was discharged from hospital the next day with a plan for the Crisis Team to complete a follow up review.
- On 16th December 2020, the Crisis Team completed a review of Thomas's mental health. He was assessed as not requiring any ongoing support from Mental Health Services and encouraged to engage with Drug And Alcohol Services.
- On 19th December 2020, Police found Thomas unconscious and speaking gibberish. It was unclear if he was intoxicated. He was taken to A&E and seen by the Psychiatric Liaison Team. There was no indication at this assessment that Thomas was suffering from an acute psychiatric illness that required further assessment.

As with his substance use, the picture of Thomas's mental state is very unclear. It is hard to determine whether he had a serious mental illness; what seems clear is that many professionals viewed Thomas as being mentally unwell.

8.3 Anti-social personality disorder

At the end of his detention under the Mental Health Act in December 2020 Thomas was reviewed by a Psychiatrist who said that there was no evidence of any acute psychopathology but there was evidence of anti-social personality traits. This is the only time that this is mentioned in the Mental Health Trust's Chronology. The Trust IMR summarises the situation saying that: *"it was initially felt Thomas was displaying symptoms suggestive of a psychotic illness, however this was reformulated as more in line with an Anti-Social Personality Disorder."*

Thomas certainly has many of the characteristics of someone with such a disorder. NICE Clinical Guideline 77 describes people with antisocial personality disorder as exhibiting: *"traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness. This is manifest in unstable interpersonal relationships, disregard for the consequences of one's behaviour, a failure to learn from experience, egocentricity and a disregard for the feelings of others…. Many people with antisocial personality disorder have a criminal conviction and are imprisoned or die prematurely as a result of reckless behaviour.*[3] This is a very close description of Thomas as he was seen in the last 12 months of his life.

This report cannot re-diagnose Thomas, and it is now impossible to say whether or not he had a personality disorder. What is noticeable, however, is that despite this suggestion in the Trust notes, he was not referred to the Mental Health Trust's own Personality Disorder Hub which provides assessment, treatment and care co-ordination for individuals over the age of 18 who have a personality disorder. It is fair to note that Thomas did not have a formal diagnosis of a personality disorder and would therefore not have been appropriate as an ongoing patient. However, the Trust's Team also provides *"scaffolding to staff in other teams who are working with people with personality difficulties"*.[4] This could have been considered as a source of advice and help on how to develop an appropriate care plan for Thomas.

NICE Clinical Guideline 77, which is aimed at healthcare professionals, notes that *People with antisocial personality disorder have tended to be excluded from services…To change the current position, staff need to work actively to engage people with antisocial personality disorder in treatment.* This did not seem to be happening with Thomas.

8.4 Two other possible drivers: Cognitive impairment or *spice* use

This section is much more speculative than the three previous sections and there is no strong evidence to support that either of these factors is a strong driver of Thomas's complex presentation. However, both are possible drivers that need to be considered in such cases.

[3] Antisocial personality disorder: prevention and management (nice.org.uk)

[4] Personality Disorder Hub Service - CNTW121 - Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Cognitive damage is very common in people with substance use disorders. A collection of American studies over the last 20 years suggests that the number of individuals receiving treatment for substance use disorders who have incurred traumatic brain injuries (TBI) may be as high as 50%.[5] This is a more significant problem in people who are dependent on alcohol than drugs; however, there are suggestions that Thomas has, at the least, a past history of heavy alcohol use.

What is clear is that in September 2020 Thomas came to A&E exhibiting "odd behaviours" after suffering a head injury. The Primary Care notes record that he had a CT scan of the brain in A&E. However, no record of the outcome of this is available in the notes and it is possible from a reading of other notes that the scan may have been sought but not proceeded with because Thomas disengaged. However the Mental Health Trust state that: *"There appears to have been an opportunity for referral to Community Acquired Brain Injury Services (CABIS) services from first contact with Psychiatric Liaison Team…This could have been explored moving forward also given apparent reported changes in presentation following reported head injury… (with) increased strange behaviours and odd thoughts following (the)head injury.*

Reviewing his history, it is likely, but not certain, that Thomas may have sustained other head injuries. For example, Police describe how he was assaulted by three men with metal bars. According to the Probation IMR[6], Thomas claims to have been assaulted in prison. In November 2020, Thomas stated that he was attacked and thrown in the River Tyne. In the Practitioners' workshop, workers from the Community Hub talked about Thomas having been beaten up several times on the estate where he lived. As with personality disorder, this is an issue which was briefly highlighted and merited further exploration.

Some of Thomas's behaviour is consistent with the use of the new psychoactive substance "spice". This is a synthetic cannabinoid: *"a laboratory-made drug which is designed to mimic the effects of cannabis. However, its effects may be much more harmful and unpredictable than cannabis."*[7] Its psychological effects are described as:

- extreme anxiety
- paranoia
- suicidal thoughts
- psychosis.[8]

Spice use is common in people who have been in prison, where its use is more easily concealed than cannabis. It may also not show up on drug tests. This is speculative, but practitioners should be alert to the possible presence of spice as a complicating factor in presentations with substance use and mental disorders.

[5] Substance Abuse and Traumatic Brain Injury | BrainLine
[6] This IMR encompasses Prison information
[7] Synthetic cannabinoids (Spice) | NHS inform
[8] Synthetic cannabinoids (Spice) | NHS inform

8.5 Moving forward

The drivers behind Thomas's complex and challenging presentation are far from clear. In retrospect, it is hard to determine what was happening with either his mental health or his substance use. For clinicians working with him, he did not fit easily into any one specific box and, therefore, it is very easy for care to become blocked because no-one had a lead responsibility.

Instead, this lack of clarity should be:

- the signal for another phase of care in which agencies worked together to build a joint management approach.

The Community Hub IMR comments that: *Thomas was a difficult person to help. His case should form the basis of a complex case study that would consider new ways of working. The central question is, how can clients like Thomas be provided with tailored solutions that avoid the pitfalls of traditional service limits.*

What is required is professional curiosity to come to a joint formulation that reflects his needs. This is easy to say and is a message repeated in many Safeguarding Adult Reviews.[9] Therefore, what is needed is not exhortations to use professional curiosity but rather:

- the development of a process that enables an ongoing, multi-agency exploration of the needs of complex and challenging individuals, particularly where there is real doubt or disagreement about the factors that drive their presentation.

The rest of this report considers possible approaches to the better management of this difficult situation. It starts by making two specific points about:

- the management of people with both a mental health and a substance misuse disorder; and
- working with clients that services find difficult to engage

The report then sets out a range of options to better meet his needs covering:

- Multiagency management
- Care coordination
- Assertive outreach
- Risk
- The use of safeguarding powers
- The use of the Mental Capacity Act
- Tackling substance use disorders
- Tackling mental disorders
- Data collection and information sharing processes.

[9] Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 | Local Government Association

This is all summarised in section 21 which reviews these key themes and the report finishes in section 23 with recommendations for action.

9. The challenge of working with co-occurring conditions

The management of co-occurring disorders has been an acknowledged challenge in England for the last thirty years. At least six guidance documents have been issued in that period by the Department of Health, NICE or PHE/NHSE. These include:

- NICE – National Guidance 58 – Co-existing severe mental illness and substance misuse – 2016
- Psychosis with coexisting substance misuse – NICE Clinical Guideline 120 – 2011
- PHE / NHSE – Better care for people with co-occurring mental health and alcohol and drug use conditions - 2017

Nonetheless, the management of this client group remains a real challenge. Thomas highlights a significant reason for this:

- The people that many agencies see as being dually diagnosed are often those where at least one of these diagnoses remains a matter of debate. They are, for example, apparently very mentally unwell, but not diagnosed with a mental illness.

This means that they don't formally fit into the framework provided by these documents. This is an almost inevitable problem when there is more than one potential diagnosis involved – the complexity inherent in the situation will generate confusion about the correct diagnosis.

Local partners will need to consider whether the approach to Thomas reached the standards set out in the national guidance. However, more specifically, Thomas highlights the need for a local pathway for people with co-occurring disorders that includes a structure that can resolve the management of people who may not have a diagnosable mental disorder but nonetheless are clearly mentally unwell. In West Sussex, the co-occurring conditions protocol has directly addressed this problem by proposing a multi-agency group that can arbitrate these debates.[10]

10. Working with clients that services find difficult to engage

Thomas had a number of aspects to his presentation – his substance use disorder, possible mental health concerns, suicidality, health issues and possible self-neglect.

[10] It should be noted that the NICE and NHSE/PHE documents do emphasise the centrality of joint working with this group. More importantly, the NHSE/PHE guidance sets out two key principles:

- "1 *Everyone's job.* Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.
- 2. *No wrong door*. Services have an open door policy for individuals with co-occurring conditions, and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point."

However, one issue underpinned all of these issues – services found him very difficult to engage constructively.

He had contact with services on frequent occasions but often in unplanned and inappropriate ways. Throughout the notes there are examples of problems engaging him:

- Throughout Thomas's Prison sentence from 2010 onwards, there was a refusal to engage with the process, to meet with staff or to participate in sentence planning. He referred frequently to a 'conspiracy' within and between agencies and those in authority working against him, consistently exhibiting a distrust of interventions and inputs.
- In the community, Thomas refused to engage with any medical interventions other than prescribing medication that he requested and often consultations ended due to abusive comments.
- In August 2020 a Tenancy Support Officer telephoned Thomas to discuss support options, Thomas was annoyed that he had been contacted. He stated he was unsure what support he would like if any, then ended the call. Further attempts were made to contact Thomas but to no avail.
- Thomas was approached by Mental Health Teams whilst in Prison in early 2021, however, again he declined to engage.

Each of these comments focuses on the relationship between Thomas and an individual professional involved in his care. It is easy, therefore, to focus on these situations in isolation rather than seeing them as a pattern that requires an organised response.

Thomas was not unusual in presenting difficulties of engagement. The Manchester Safeguarding Partnership *Carers Thematic Learning Review 2021* identifies the same issue: *The challenges of supporting adults who do not consent to treatment or support and who are judged to have the capacity to make those decisions in an informed way…*

The review goes on to comment on: *a sense that their persistent refusal of offers of care and support were perhaps too readily accepted, perceived and interpreted by practitioners as 'non-compliance' rather than as a form of self-neglect, which was a product of the adults' adverse life experiences, poor quality of life and very challenging day to day living*.

In Thomas's case, it was important to consider whether his aggressive presentation obscured his real needs.

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

Thomas's situation highlights the need for:

- A specific published procedure to guide professionals in dealing with client non-engagement (this section).
- Care coordination and multi-agency management (next sections).

Both the Acute Hospital and Adult Social Care IMRs highlight the challenge for professionals in dealing with client non-engagement: Adult Social Care talk about the need for *Awareness over when to share information and seek further guidance on complex cases.* The Hospital talk about: *The importance of knowing when to escalate or refer complex cases.*

To address this it will be useful to develop guidance that covers:

- how to judge the level of risk or vulnerability that warrants ongoing, assertive action; and
- how to escalate these concerns and where they should be escalated to.

This guidance, whether single agency or multi-agency, would also benefit from information on what techniques work with people that services find hard to engage, i.e. how to practically intervene with such individuals. This is an under-developed field. The SAR author looked for national guidance on this issue as part of the drafting of this report but could not find an overarching guidance document. Reports such as "The Keys to Engagement" (mental health)[11] and "The Blue Light Project" (alcohol misuse)[12] have addressed this issue with specific client groups but there is no single guidance document. Whether at a local or a national level, such guidance will be a vital support to those working with people who are difficult to engage.

11. Multi-agency management and care coordination

The material in the two previous sections both point in one direction: the care of people with Thomas's complex presentation will benefit from the clear leadership provided by a multi-agency management structure to which these challenging individuals can be escalated. This would have facilitated professional debate about his complex presentations and uncertain diagnoses.

In the last year of his life, Thomas was subject to multi-agency work. For example:

- The Ambulance Service reported a good level of partnership working. Discussions were held with other agencies relating to medications, information was shared about risk towards staff.
- Housing reported that during their assessment process appropriate agencies were contacted including Police, Prison Service and Probation. Information was shared between agencies in relation to risk.
- The Mental Health Trust reported that there were appropriate demonstrations of multi-agency working and information sharing in relation to Thomas e.g. evidence of engagement with Drug and Alcohol services or Probation.

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

However, multi-agency work is not the same as multi-agency management. He was also subject to a local MAART complex case meeting in September 2020. This was repeated again in December 2020. Effectively these were one-off meetings but certainly in the first case an action plan was formulated with actions to be taken by the individual agencies.

These efforts were positive; however, they do not appear to have been sufficiently persistent or comprehensive. The Ambulance Service, which was seeing him regularly, believed that there was a missed opportunity to come together as a partnership and collectively risk assess and risk manage. The Community Hub commented that better communication would have possibly generated more co-operative work across agencies earlier.

Thomas would have benefited from escalation to regular multi-agency discussion involving Criminal Justice Services, Community Safety, Emergency Services, Health, Mental Health, Drug & Alcohol Services, Adult Social Care and Housing Services, among others. This group could have ensured:

- Information was shared
- Points of disagreement (e.g. diagnosis) were debated
- A jointly owned plan was developed
- Agencies were challenged to try different approaches
- Work continued until Thomas's behaviour allowed him to engage positively with services.

A regular multi-agency framework would also have facilitated agencies identifying the deterioration in his well-being in the last months of his life.

Gateshead could benefit from having a permanent specialist multi-agency group that focuses on this client group. This would provide a standing, expert group for managing this client group rather than requiring ad hoc meetings. This approach has worked well in other areas e.g. Sandwell, Northumberland. This group would also provide a focus for expertise on working with a very challenging group. The local Mental Health Trust is already part of one such group in Northumberland – The Blue Light Group.

Multi-agency management of Thomas would also have enabled discussion of a range of issues that were central to his care e.g. mental capacity, cognitive impairment or escalation to a more senior group.

11.1 Multi-agency Public Protection Arrangements (MAPPA)

A question raised by the SARCC group was why Thomas was not managed through the MAPPA framework. He appears to qualify for MAPPA Category 2 – as a violent offender who had a term of imprisonment of 12 months or more. It is unclear why he was not under the MAPPA framework when he was released in either early January 2020 or March 2020.

In September 2020, as a result of the risk he posed a referral was made for him to come under MAPPA. This referral was not accepted. The MAPPA referral panel felt that although he had displayed aggression and mental health issues, this had been the case for some time, and he did not appear to be presenting any different risks. A further referral was considered in December 2020, but Thomas's subsequent remand and then death, meant that this became irrelevant.

The Probation IMR comments that: *An earlier referral into Level 2 MAPPA to give more time for consideration and planning would have been good practice given the risks Thomas was deemed to continue to present to his ex-partner and mental health and homelessness concerns.* This appears to indicate the need for local discussion or training about MAPPA access

11.2 Care Co-ordination

As has been said about multi-agency management, many agencies and professionals were in contact with Thomas, yet no one person seems to have taken on a care coordination role with him.

His care would have benefited from clear leadership: a care coordinator as well as multi-agency management. These two elements would have fed off each other:

- having a care coordinator would have supported regular multi-agency meetings and supported focused discussions within those meetings, and
- regular meetings could equally have driven the appointment of a care coordinator.

12. Assertive outreach

This multi-agency approach would have been more powerful if it was supported by assertive outreach. An assertive outreach approach is built on the recognition that with complex individuals such as Thomas, agencies are going to need to sustain the relationship rather than expecting him to be able to do that.

This would have been characterised by:

- Meeting him in the community
- Enabling an understanding of his living circumstances
- Being intensive
- Being flexible in its approach
- Focusing on building a relationship
- Focusing on all the client's needs and concerns rather than e.g. just the drugs or alcohol
- Being persistent and consistent
- Taking the time needed to build the relationship.

Once professionals had a better understanding of what was behind this pattern of non-engagement, they can begin to think about ways in which his needs can be better addressed. This might have ranged from using practical harm reduction approaches

through to an outreach worker being present at appointments with him, the use of motivational interviewing and on to a better understanding of how the Mental Capacity Act could be used in his case.

In the ideal scenario, Thomas would need someone to work with him and build a relationship with him. It is acknowledged that this would have been very difficult with Thomas because of:

- The high level of risk associated with him – which would, at the least, have required two workers to see him; &
- The Covid restrictions which were in force at the time.

Nonetheless, in other circumstances, assertive outreach would have been a valuable tool in working with Thomas and it would be useful to have the commissioned capacity to provide this with clients that services find difficult to engage. This, or some elements of it, could be based in specialist Alcohol Services.

13. Risk

The SARCC group was particularly interested in the identification and management of risk. Thomas clearly posed a significant risk to other people; most obviously his family but also other professionals. He made serious threats to a staff member in the Drug and Alcohol Service and, in Primary Care, had to be transferred to the Special Allocation Service. However, the IMRs suggest that agencies were generally aware of the risk of violence associated with Thomas and steps were taken to mitigate this.

Nonetheless, Thomas's death is a reminder that people who are chaotically aggressive to others, also pose a risk to themselves. For example, he was probably the victim of aggression from people on his estate. Specifically, it is highlighted in the nature of his death, an apparently random overdose as the result of chaotic drug use.

13.1 The overdose – a reminder of the risks

The number of people with drug use disorders who die drug related deaths has been increasing steadily over the last decade. This is a national priority for action. Thomas's death is a reminder of two risks that drug users run.

- The risk of drug users being discharged from Prison or Hospital after a period of abstinence, reinstating drug use at previous levels and then dying because their tolerance to drugs has dropped.
- People die overdose deaths because lung function is compromised by the depressant effects of certain drugs. Therefore, other factors that compromise lung function will increase this risk. In Thomas's case he had two such factors. Over the long term he had a pattern of smoking which could have affected lung function. In the short term, while he was in Prison in January 2021, he had Covid. Again this could have affected lung function.

It is hard to be clear whether either of these factors was a direct cause of Thomas's death; however, it is appropriate to use this incident as a reminder to local professionals of these two dynamics.

13.2 Domestic violence – a note

Thomas had a very significant history of domestic violence which resulted in him serving ten years in prison. However, this is largely outside the review period and therefore has not been addressed in this report.

14. Safeguarding and other Adult Social Care interventions

This section focuses on adult safeguarding; however, Thomas also had two teenage children. Nothing in the IMRs suggest that during the review period they were at risk from him or that any further steps were required to protect them.

Thomas was an adult with care and support needs and the Care Act could have provided a framework for addressing the challenges he posed, as well as protecting him from further harm. Three safeguarding concerns were raised about him during the review period:

- In January 2020, the Police twice raised concerns about his paranoid behaviour (13th and 14th January); however these did not proceed to a safeguarding inquiry. It is not possible to determine whether this was the correct decision at that time, but given the subsequent problems that emerged earlier intervention could have been helpful.
- In September 2020, concerns were raised by the Neighbourhood Management Team about Thomas's behaviour and deteriorating Mental Health. This resulted in a complex case meeting being convened by the MAART team.

This raises the question as to whether there were missed opportunities to raise safeguarding concerns. This is acknowledged within the IMRs:

- The Ambulance Service say that there were no safeguarding concerns raised in relation to Thomas within the review period. They acknowledge that this was a missed opportunity to allow the partnership to come together and collectively risk assess based on wider information.
- The Police IMR also acknowledges that there were times when Adult Concern notifications were not submitted by officers. For example, in November 2020 Officers found that Thomas's flat was a mess with his belongings lying all over the place. He had a foot injury and was on crutches and was tripping all over the flat.
- IMRs specifically acknowledge that no safeguarding concerns were raised by the Acute Hospital Trust, the Adult Social Care Mental Health Team or Primary Care.

In addition to the questions about safeguarding, the Adult Social Care IMR also highlights that throughout the review period, no Section 9 assessment of his care and support needs was ever undertaken. This is acknowledged to be a gap and would certainly have been increasingly appropriate in the last months of his life. The Community Hub identify him as living in very poor circumstances: *Thomas lived in a*

sparse flat with a bed turned on its end to provide privacy as there were no window coverings. Thomas had a TV which was damaged when the table it was on collapsed. It was clear that the furniture pack had not been assembled properly and the screws were loosely fitted or absent causing the table to collapse with the TV on top.

This was especially important in the period after discharge from his detention under the Mental Health Act. The key agencies have different views as to whether a social care assessment was sought by Mental Health staff at this point. Adult Social Care say that this did not happen. Mental Health Services disagree. It is possible that this divergence is a result of different understandings of Adult Social Care's contribution to the Mental Health Act Tribunal. Nonetheless, at this point Thomas himself made contact with Adult Social Care who acknowledge that, Thomas could have been offered a Care Act assessment to determine if he had any needs for care and support.

All of this raises questions about whether agencies are recognising the need to safeguard, and seek Section 9 Assessments about, individuals with challenging presentations like Thomas. Does an aggressive and confrontational persona hide the fact someone may have very real vulnerabilities. It is positive to note that the Drug and Alcohol Services IMR suggests that there has been a change in recognition and understanding locally about substance use being an identified care and support need under the Care Act. However, the need to challenge any ongoing lack of recognition of the need for Adult Social Care to work with such individuals may be important learning from this review.

15. Using the Mental Capacity Act

Most agencies acknowledge that Thomas's mental capacity was not assessed.

- The Ambulance Service IMR states that *There were no occasions when staff formally assessed (Thomas's) mental capacity.*
- The Acute Hospital IMR states that *it is unclear whether his capacity was ever discussed or assessed as there is no reference to this made in any documentation…No MCA or DOLs were completed.*
- The Primary Care IMR states that: *Due to the presentations described there was not an opportunity to use the MCA.*

On the other hand:

- The Police IMR refers to a situation in which Thomas was the victim of an attack but refused to seek medical help. *The Officer involved noted that: "Adult at risk lacks mental capacity to provide consent."* However, the basis for this statement is unclear and no action was taken as a result of it.

In late November 2020, during a mental health crisis, clinicians did assess that Thomas *lacked capacity to consent to treatment and care* so a Mental Health Act Assessment was arranged for later that same day. In mid-December he was discharged from Psychiatric Hospital and the Housing Provider's IMR states that at

this point: *Thomas was assessed and found to have capacity*[13]. However, the Mental Health Trust does not make it clear whether there was a mental capacity assessment at this point. This may be a misunderstanding and the Housing Provider's staff member may be describing his discharge from the Mental Health Act as "having capacity".

Thomas's situation highlights three issues related to the use of the Mental Capacity Act:

- A very specific training need highlighted by the Police Officers' assessment of a lack of capacity but their failure to take further action as a result;
- The need to remind all professionals of the importance of considering mental capacity with these complex and challenging clients. An aggressive rejection may appear capacitated but may conceal someone who is struggling to manage their well-being.
- The importance of considering "executive capacity" when assessing the capacity of vulnerable and self-neglecting individuals like Thomas.

The Teeswide Carol SAR (about a chronic dependent drinker) talks about the need to look at someone's "executive capacity" as well as their "decisional capacity". Can someone both *make* a decision and *put it into effect* (i.e. use information)? This will necessitate a longer-term view when assessing capacity with someone like Thomas. Repeated refusals of care, as happened with Carol, should raise questions about the ability to *execute* decisions. The draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function and to consider repeated failed decisions when assessing capacity.

Again, the lack of a clear multi-agency framework and clear leadership around Thomas's care would have hindered the use of the Mental Capacity Act. Within a multi-agency meeting, professionals could have considered his mental capacity from a number of angles and have professionally challenged situations in which they felt that the approach was inappropriate.

Ultimately, even if it is argued that Thomas was capacitated, this should not have been the end of his care. The report of *The 2013 Mental Capacity Act 2005: Post-Legislative Scrutiny*, criticises the use of the Act in this way: *The presumption of capacity…is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm.*[14] The MCA Code of Practice repeatedly highlights the need to assist capacitous people with their decision making[15] or to undertake *further investigation in such circumstances.*[16]

16. Responding to his substance use disorder

16.1 Overview

[13] The nature of the decision referred to is not made clear.
[14] Mental Capacity Act 2005: Post-Legislative Scrutiny 2013 105
[15] Mental Capacity Act 2005: *Code of Practice 1.2*
[16] Mental Capacity Act 2005: *Code of Practice 2.11*

As has been said above (section 9) Thomas had a substance use disorder which, undoubtedly, had a significant impact on his life and on the problems that led to his death. This section considers the responses to this.

Thomas was engaged with Drug and Alcohol Services for almost the entire period under review. In January 2020, he was linked in to them for the continuation of a methadone script that had begun while in Prison. Both then and subsequently, the Service was responsive to his treatment wishes. When he reported he wished to reduce off his methadone prescription, this was supported following a medical review. His wishes were further supported when he identified in April 2020 that he wished to convert to Buprenorphine.

His actual engagement with the service, albeit continuous, was very chaotic. At times he was seeking abstinence and residential rehabilitation at other times he was seeking changes to his buprenorphine script, other medications or practical help such as a replacement mobile phone. More seriously at times he was threatening members of staff, e.g. to slash the face of a female staff member.

The Service worked hard to engage and develop a therapeutic plan for Thomas. Multi-disciplinary discussions were utilised appropriately in order to discuss and attempt to mitigate identified risks and ensure treatment planning was effective. However, it is also fair to say that there was very little forward movement over this period, therefore it is important to consider alternative approaches.

16.2 Residential rehabilitation

The best pathway for Thomas would probably have been a period of residential rehabilitation in a "drug free environment". This would have enabled:

- A time away from his home situation in a protected environment
- A chance to properly assess his mental health and possible cognitive impairment
- A chance to address the substance use disorders and develop an appropriate care plan.

Thomas did identify a wish to go into residential rehabilitation at a unit in Northumberland in September 2020. The Drug and Alcohol Services discussed preparation for this with him; however he decided he did not want to reduce and then cease his Buprenorphine as required for abstinence based rehabilitation.

Following his inpatient admission in December 2020, he ceased his opiate replacement treatment, however following discharge there was no opportunity to review whether he wished to pursue a rehabilitation stay prior to his being remanded in custody.

Residential rehabilitation would not have been an easy answer to Thomas's problems. It is likely that there would have been challenges finding an appropriate placement. However, the review considers that, given the range of possible care packages, some form of "drug free" residential rehabilitation would have been the best option. This is supported by Dame Carol Black's *Review of drugs part two: prevention, treatment,*

and recovery which has highlighted the *evidence of (its) effectiveness and importance for people with particularly complex needs.* This is also specifically acknowledged in the Drug and Alcohol Service IMR.

Access to residential rehabilitation may not have been a simple route to the resolution of Thomas's problems. However, it is important that:

- persistent efforts should be made to "sell" this approach to appropriate individuals like Thomas, by all professionals;
- funding should be available via commissioners for this approach without unreasonable barriers; and
- commissioners should support and encourage the development of residential facilities that will work with more complex drug use disorders including those with possible mental disorders or cognitive impairment.

16.3 Tackling substance use disorders: a community pathway

Given that residential rehabilitation was a challenging option, consideration needs to be given to whether there are alternative pathways in the community. A range of evidence now identifies "what works" with difficult to engage chronic substance misusers. This is most clearly summarised in Alcohol Change UK's Blue Light project manual.[17] However, the Office of Health Improvement and Disparities' (formerly Public Health England) forthcoming clinical guidelines on alcohol, the Carol SAR from Teesside and the Alan SAR from Sunderland provide examples of other endorsements of this approach.

This reflects what has already been suggested within this report:

- A care package centred on intensive assertive outreach.
- A co-ordinated multi-agency management approach to guide and support the work.
- The willingness to be consistent and persistent and to allocate time to the task

With people like Thomas, services need to move beyond the expectation that clients will engage with them and towards recognising that, for this more complex group, efforts will need to be made to engage them.

This is not a criticism of the Drug and Alcohol Services. Rather this is a recognition that these services need to be commissioned and developed to have the capacity to work effectively with this type of individual. Similar services in other parts of the country e.g. Sandwell, Northumberland, Westminster or Surrey have been designed with this capacity.

16.4 The management of buprenorphine in Hospital

Thomas's care highlights a technical point about the management of Buprenorphine in Hospital. The Mental Health Trust IMR reports that an internal review had noted that Thomas's Buprenorphine was stopped during his inpatient admission in December 2020. The Medical Officer within the internal review advised that for

[17] For transparency purposes it should be noted that the author of this report is the co-author of the Blue Light project manual.

patients that have longstanding difficulties with opiates, continuing to prescribe opiate replacement is recommended even after a period of abstinence. The internal review recommended that: *Ward staff… be reminded about the risks of stopping opiate replacement in an unplanned manner.*

17. Responding to Thomas's mental health

17.1 A more collaborative approach

The response to Thomas's mental health needs is hard to evaluate. As has been said there were very conflicting pictures of his mental health – a man who demonstrated bizarre and paranoid ideas but whom Mental Health Services regarded as not having a diagnosable mental health illness (in particular following an assessment and inpatient stay under the Mental Health Act).

The report cannot re-diagnose Thomas; however, while Thomas may not have had a diagnosable mental health problem, many professionals felt that he was mentally unwell. Therefore, a more ongoing and collaborative approach was required and other services would have greatly benefited from support from Mental Health professionals in discussing how to move forward with this man's care; particularly in the light of comments that he may have had anti-social personality traits.

This raises an important question:

- What is the ongoing role of Mental Health Services with people in Thomas's situation – unwell but not diagnosably mentally ill? What is the responsibility of a Mental Health Trust to people like Thomas who appear "to fall between the lines" of services? It would be helpful to have ongoing support from Mental Health Services to develop a care plan for someone with anti-social personality traits even if they are not to be an ongoing client of the service.

In the Practitioners' workshop, workers commented on the significant impact of the statement that Thomas "does not have a mental health problem". One practitioner stated that it had a "paralysing impact on services". For example, Adult Social Care felt that it impacted on the way services responded to Thomas.

As has been said above, disagreement exists on the adequacy of his discharge from Section 2 in December. Neither Social Care nor Housing believe they were consulted – Adult Social Care describe this as *"poor discharge planning"* by Mental Health Services. Mental Health Services disagree with this view and believe steps were taken.

Again, it is not the role of this review to adjudicate this disagreement. This review simply argues that, even if Thomas did not require further intervention from secondary care Mental Health Services, he did require an approach that ensured ongoing intervention in the community. This is justified both by his poor mental health and the level of risk he posed to himself, professionals and the wider community.

18. Data collection and information sharing

If better responses are to be developed to people like Thomas, it will be vital to collect accurate data on the impact and nature of his substance use. The understanding of Thomas's conditions is hampered by the lack of a clear picture of his alcohol use, but possibly also his other substance use.

Two areas of action are possible here:

- The use of alcohol and drug screening tools
- The use of the Police alcohol flag

In addition the IMRs highlighted a more specific issue about information transfer from the Prison system.

18.1 Alcohol and drug screening tools

Thomas's case is a reminder of the importance of robust drug and alcohol screening processes to ensure that any risk is identified and highlighted. In accordance with NICE Public Health Guidance 24, professionals working with the public need to be alert to the possibility of alcohol use disorders and should be routinely asking the questions in the AUDIT alcohol screening tool[18] as well as using professional curiosity to explore this issue. Equivalent drug screening tools are available and should also be used. Best practice would ensure that these tools are routinely being used by all relevant professionals, whether in Primary Care, Mental Health Services, Adult Social Care, Housing or any other adult service.

In addition, it should be asked whether Mental Health Services are using drug testing to validate assessments which suggest that substance misuse is the main driver of a specific presentation.

18.2Police data collection

Similarly, the response to alcohol will be greatly enhanced if the Police:

- Collect good alcohol specific data by encouraging consistent and accurate use of the alcohol flag in accordance with the *Counting rules for recorded crime*[19]*.* This will require good recording by officers. The alcohol flag has been mandatory since 2017; however, its use is inconsistent nationally.[20]
- Ensure that, as far as possible, data on alcohol is not hidden under labels such as "mental health" or "substance misuse". This will hinder the development of appropriate responses.

18.3 Information transfer

The IMRs highlight three points at which the transfer of important information between agencies was hampered:

[18] Alcohol Use Disorders Identification Test (AUDIT) (auditscreen.org)
[19] Counting rules for recorded crime - GOV.UK (www.gov.uk)
[20] E.g. West Yorkshire FMS acknowledges inconsistent use of the flag in the NTE

- Thomas's healthcare was transferred from his GP to the Special Allocation Service (SAS). At that point, a delay in the transfer of the records was often occurring. In his case a printed summary of medical history and recent contacts was sent to the SAS practice in May 2020 but GP2GP[21] transfer did not work. This problem has subsequently been addressed centrally and GP2GP transfer now occurs.
- In April 2020, two documents from the Prison Medical Service were sent to Thomas's GP but they are described as *poor quality info without any details. Chronic pain is mentioned, as are several episodes of violence towards staff and advice that he is not seen alone. He appears to have been prescribed mirtazapine and gabapentin. The indications for these are unclear.*
- In February 2021, there does not appear to be any notification to the GP of him leaving Prison.

The first of these is hopefully resolved. However, work may be required to ensure adequate communication from Prison Health when planning for discharge.

19. Additional point - Covid 19

Much of the period under review was during the Covid-19 restrictions. This will have impacted on Thomas's care. For example, it would have been harder to have pursued an assertive outreach or other community approach in this period. This needs to be acknowledged when considering his care.

There are points in the IMRs where the impact of the Covid restrictions is highlighted. For example, Housing staff were having limited face to face contact and therefore a number of assessments and interventions were carried out over the telephone. Information on Thomas was harder to access from the Prison because Prison Support Officers had been removed from Prisons due to Covid.

On the other hand the local Community Hub set up by the Council to offer help with a variety of service issues across the council during the pandemic period was a real positive for Thomas and provided a central point of contact that he might not have had at other times.

It is not possible to draw a direct line between the Covid restrictions and Thomas's death. Therefore, no comments have been made on this.

20. Key Learning Points

[21] GP2GP is the term used for a process that allows a patients' full electronic patient record (EPR) to be exported, transferred and imported between the clinical systems of different Practices when a patient moves practice.

Thomas presented challenges to services at a number of levels, not least because he threatened serious violence to staff members and asked for practical help or prescribed medications in an aggressive manner.

Nonetheless, the key challenges were that Thomas was:

- difficult to diagnose; &
- difficult to engage in services.

It was very unclear whether the main driver behind Thomas's complex presentation was his mental health, his substance use or possibly even a pattern of cognitive impairment. This became particularly crucial in December 2020 when after detention under section 2 of the Mental Health Act, he was discharged because he was assessed as not having a diagnosable mental illness.

Such situations where there is disagreement about the complex nature of someone's presentation are not unusual. What is required to address this is not just professional curiosity but rather:

- a multi-agency process of professional curiosity.

In the face of this complexity, services should be coming together to consider Thomas's presentation and how best to address it. This review is suggesting that there should be a:

- Local policy on how to manage clients who are difficult to engage in services and
- A clear multi-agency location to which such complex cases can be escalated.

This local policy or procedure will need to provide guidance on:

- how to judge the level of risk or vulnerability that warrants ongoing, assertive action;
- how to practically intervene with hard to engage clients; and
- how to escalate these concerns and where they should be escalated to.

The need for this type of guidance was endorsed by the Acute Hospital and Adult Social Care in their IMRs.

To facilitate this process of professional curiosity, Gateshead would benefit from a standing specialist multi-agency group that focuses on this client group. This would provide a standing, expert group rather than requiring ad hoc meetings. This approach has worked well in other areas e.g. Sandwell. This group would also provide a focus for expertise on working with a very challenging group. The local Mental Health Trust is already part of one such group in Northumberland – The Blue Light Group.

Thomas would also have benefited from:

- Care coordination and

- Assertive outreach.

Many agencies and professionals were in contact with Thomas, yet no one person seems to have taken on a care coordination role with him. This would have linked to the multi-agency management meeting. A care coordinator would have supported regular multi-agency meetings, and regular meetings could equally have driven the appointment of a care coordinator.

More specifically, in the ideal scenario, Thomas would need someone to work with him and build a relationship with him: an assertive outreach worker. This would have been difficult with Thomas because of the high level of risk associated with him and the Covid restrictions. Nonetheless, in other circumstances, assertive outreach would have been a valuable tool in working with someone like Thomas and it would be useful to have the commissioned capacity to provide this with clients that services find difficult to engage. Some of this capacity could be based in specialist Drug and Alcohol Services.

Three safeguarding concerns were raised about Thomas during the review period. The last of these resulted in a complex case meeting being convened by the MAART team towards the end of his life. However, multiple IMRs also indicate that there were missed opportunities to raise safeguarding concerns. The Adult Social Care IMR also highlights that throughout the review period, no Section 9 assessment of his care and support needs was ever undertaken. This is acknowledged to be a gap and would certainly have been increasingly appropriate in the last months of his life. It was particularly important that this occurred at the point of discharge from Section in late 2020. Why it did not happen is a matter on which there is disagreement, nonetheless action was needed at that point.

All of this raises questions about whether agencies are recognising the need to safeguard individuals with challenging presentations like Thomas. Does their substance use or aggressive and confrontational persona hide the fact that they may have very real vulnerabilities. The need to challenge any ongoing lack of recognition of the need for Adult Social Care to work with such individuals may be important learning from this review.

A similar point can be made about the use of the Mental Capacity Act. Thomas's situation highlights three points:

- A very specific training need highlighted by a Police Officers' assessment of a lack of capacity but the failure to take further action as a result;
- The need to remind all professionals of the importance of considering mental capacity with these complex and challenging clients. An aggressive rejection may appear capacitated but may conceal someone who is struggling to manage their well-being.
- The importance of considering "executive capacity" when assessing the capacity of vulnerable and self-neglecting individuals like Thomas.

Thomas had a pattern of substance use disorders. In general, these were well managed by the Drug and Alcohol Service. Consideration was rightly given to a

residential pathway, which would probably have been the ideal option for Thomas. Faced with the rejection of that approach, the best approach would have been a community pathway reflecting what has already been suggested within this report:

- A care package centred on intensive assertive outreach.
- A co-ordinated multi-agency management approach to guide and support the work.
- The willingness to be consistent and persistent and to allocate time to the task

This would have been assisted by the Drug and Alcohol Services having commissioned capacity to undertake assertive outreach with people like Thomas. This is a model being used in Northumberland.

Thomas's care also highlights a technical point about the management of Buprenorphine in Hospital. The Mental Health Trust IMR notes that: *Ward staff (need) to be reminded about the risks of stopping opiate replacement in an unplanned manner.* This highlights a very specific training need.

There were very conflicting pictures of Thomas's mental health with Mental Health Services ultimately coming to the view that he did not have a diagnosable mental illness. It is, of course, futile to "re-diagnose" him at this point. However, what Thomas's care highlights is the need for a more ongoing and collaborative approach to clients who are difficult to diagnose.

Thomas may not have had a diagnosable mental illness but he was experiencing problems with his mental health. Other services would have greatly benefited from support from Mental Health professionals in discussing how to move forward with his care. For example, the Mental Health Trust has an Anti-Social Personality Disorder Team. This team could usefully have provided advice on the ongoing management of his anti-social personality traits. This suggests the need to develop and clarify this pathway.

(NB The Practitioners' workshop commented specifically on the significant impact of the statement that Thomas "does not have a mental health problem". One practitioner stated that this had a "paralysing impact on services".)

The nature of Thomas's presentation highlights the interface between Mental Health and Drug and Alcohol Services. These should be governed by three pieces of national guidance (two from NICE and one from NHS England). It is important to ensure that work with people like Thomas is consistent with this guidance and in particular with the NHSE guidance that co-occurring disorders are *everybody's job* and that there should be *no wrong door* for these clients.

The report also raises three points about data collection. His care highlights gaps in the sharing of information between the Prison system and Health Services. However, in particular, the challenge is that there was a lack of a detailed understanding of the nature of his substance use. This highlights the importance of standardised screening tools. In particular, following NICE Public Health Guidance 24, the AUDIT alcohol screening tool should be widely used by all frontline professionals to provide a consistent means of communicating information about alcohol-related harm. Similar

tools are advocated for drug users. It is also important that the Police alcohol flag is used consistently where this is appropriate.

21. Good practice

Many agencies made efforts to help Thomas. Most professionals appear to have worked appropriately within the framework of their individual disciplines. In particular, much of the work undertaken with him was during the period of the Covid-19 restrictions and it is clear that agencies continued to work and maintain services during that difficult period.

However, specific points of good practice also emerge:

- It is commendable that Thomas was never street homeless upon release. Agencies liaised prior to release to ensure that suitable accommodation would be ready. Services were flexible and adapted to meet his needs: Thomas's temporary accommodation address was turned into his permanent tenancy, this helped to reduce stresses from moving from where he was relatively comfortable.
- The local Community Hub set up by the Council as a temporary Covid response provided positive support to, and advocacy for, Thomas.
- During Thomas's time in both temporary accommodation and his tenancy, there were several licence breaches. Housing Officers worked with Police and Probation to support Thomas rather than act to enforce tenancy conditions.
- The Drug and Alcohol Service worked to support Thomas into residential rehabilitation and although this did not happen, the focus on this was good practice.
- The Drug and Alcohol Service generally continued to work with Thomas despite some very challenging behaviours.

22. Recommendations

Recommendation A
Gateshead SAB should ensure that there is a collaborative approach by Mental Health and other services to the care of people with complex presentations, especially where there are difficulties in accurate diagnosis.

Recommendation B
Gateshead SAB should develop a multi-agency protocol on managing people that services find difficult to engage. This should:

- include the development of a multi-agency management structure for this client group
- encourage the use of a care-coordination approach.

Recommendation C
Gateshead's Public Health Commissioners should ensure that the needs of people with substance use disorders that services find difficult to engage are considered in

any local needs assessment or commissioning plans. In particular, consideration should be given to developing assertive outreach capacity for this group.

Recommendation D
Gateshead SAB should ensure that agencies and individual professionals are recognising the need to safeguard individuals with challenging presentations like Thomas.

Recommendation E
Gateshead SAB should remind all professionals of the importance of:

- considering mental capacity with these complex and challenging clients.
- considering "executive capacity" when assessing the capacity of vulnerable and self-neglecting individuals like Thomas.

Recommendation F
Gateshead's Public Health Commissioners and the Integrated Care Board should review the response to people with co-occurring disorders to ensure that it is consistent with national guidance.

Recommendation G
Gateshead SAB should remind all professionals of the importance of collecting accurate data on alcohol and drug use through screening tools such as the AUDIT screening tools and related drug tools and also through the Police actively using the alcohol flag.

Appendix 1 Key Lines of Enquiry

As a minimum this SAR will explore the following overarching areas:

- Were all the staff involved aware of and sensitive to the views, needs and wishes of the adult(s), their carers or appropriate representative/advocates?
- Was there clear focus upon the adult(s) and their needs, is this evidenced in records?
- What relevant internal policies and procedures were in place during the timeframe of this review?
- How well were those policies and procedures applied?
- Did practice adhere to local Safeguarding Adult's Policies and Procedures?
- Were all required/relevant agencies/professionals involved?
- Were assessment and risk assessment procedures adequate to identify the individual's needs?
- Were there problems relating to multi-agency working, communication and/or information sharing?
- Was there appropriate use of the Mental Capacity Act / Mental Health Act?
- Were care plans adequate to meet the client's needs?
- Are there any training / professional development needs identified as a result of this case?

Specific questions pertinent to this review include:

- How well did professionals address the person's mental health needs?
- How well did professionals address the person's substance misuse needs?
- How well did professionals address the co-occurring substance misuse and mental health needs?
- How well did processes work at the point of prison discharge?
- What was the Impact of COVID 19 on service delivery?