Safeguarding Adult Review
Adult D

Final

Author: Mike Ward

Commissioned by Luton Safeguarding Adult Board
July 2022 Final

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1. Introduction

In the early hours of December 29th 2020, Police Officers were alerted to an injured person in a sleeping bag outside a block of flats in Luton. The person was later identified as Adult D, a 53 year old Polish woman who lived in the flats. Paramedics were called and she was taken to hospital. CCTV identified four people carrying Adult D from the flat to where she was found. Blood trails were found in the lift, communal hall and outside the flat. Inside the flat there were four individuals and also a mattress with a significant amount of blood on it.

The four individuals were taken into custody, on suspicion of grievous bodily harm. However, on December 30th, Adult D died in hospital as a result of head injury and liver disease. Initially the case became a murder investigation; but due to Adult D's medical condition, it was hard to ascertain whether the head injury was due to a fall or an assault and, therefore, whether there was any third party involvement. As a result, it was decided that there would be no prosecution. Both Adult D and the people initially considered as potential offenders were heavy drinkers.

The circumstances of Adult D's death were referred to the Luton Safeguarding Adult Board for consideration as a Safeguarding Adult Review (SAR). A Rapid Review of the case was undertaken which highlighted a number of areas of potential learning e.g. detoxification pathways, domestic abuse and exploitation. In July 2021, following discussion and reflection, the SAR/CSPR group decided that a SAR should be undertaken.

The purpose of SARs 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 SAR is about learning, not blaming, and aims to improve future practice through recommendations to the Board.

This SAR covers a period from January 2018 until just after Adult D's death in January 2021. A multi-agency panel of the Board set up to oversee the SAR identified those agencies that had or may have had information about Adult D during this period. Agencies were also invited to include any other information they considered relevant outside the time period identified and draw it to the attention of the panel. The multi-agency panel commissioned an independent author to complete the review – Mike Ward.

2. Methodology

Following the agreement of terms of reference for the review (see appendix 1), the author was supplied with a series of relevant documents:

A briefing template from each agency that was completed for the Rapid Review meeting - this contained basic information on the case and a chronology

- The notes of the Rapid Review meeting
- An Independent Management Report from each agency involved

The following agencies were involved in the process:

- East London Foundation NHS Trust
- GP / Primary Care
- Housing
- Keystage Housing
- Luton and Dunstable University Hospital
- Luton Council ASC MASH
- Noah
- Police
- Resolutions
- Rough Sleepers team

An initial SAR review panel meeting was held in September 2021 to discuss the process and timeline of the review. A further Review Panel was held in December 2021 which agreed the key themes of the report. A Practitioner Reflection Day was held on 17th January 2022 and contributed a range of thoughts and views on Adult D and her care.

All this information was analysed by the report writer and an initial draft of this report was produced and this went to the Review Panel in February 2022. Further changes were made over the next two months, and a final draft was completed in March 2022.

3. Family contact

An important element of the process was contact with Adult D's family. She had four children (the majority adults), a brother living in England and a sister living in Poland. The author had a conversation was her brother, who supplied a range of useful information about both Adult D's background and the last years of her life which have informed this report. He made it clear that her children did not wish to engage with the review. The possibility of a conversation with Adult D's sister in Poland was raised by the author but this did not happen.

4. Background and personal Information

Adult D was a 53 year old woman who was living in temporary accommodation, where she was assaulted on the 29th December 2020 and left on the street outside the building. She passed away in hospital the next day. The coroner's reports stated that the cause of death was head injury and liver disease. She had had a number of falls before her death and, therefore, it was hard to ascertain whether the head injury was due to a fall or an assault. Therefore, no prosecutions resulted from this tragedy.

She was a woman of Polish nationality, who had come to England in 2008 at the suggestion of her brother who was already in the country. Although her brother provided some information about her and her family, little is known about her past and what may have triggered her drinking.

Initially she lived and worked in London. Her husband joined her a little later and they ultimately had their four children with them as well. The four children vary in age from 27 to 10 and the youngest now lives with his father. The relationship with her husband ended and in 2017 she moved to Luton with another man. Her brother described this move as an attempt to escape bad influences in London.

She is reported to have spoken reasonably good English, but appreciated having access to Polish-speaking workers in Noah (a local charity working with people struggling against homelessness and exclusion) and Resolutions (drug and alcohol services).

For much of the period under consideration she had no recourse to public funds which meant she survived for many years in a precarious situation which would have meant dependency on other people and a raised risk of exploitation. However, in June 2020, as a result of help provided by Noah, Adult D received full settled status which meant that she was entitled to, and in receipt of, all relevant financial support from the UK government including universal credit, housing benefit and any treatment costs.

Her lack of recourse to public funds meant that her housing situation had been precarious and at times she was living on the street or in cheap hotels. In January 2019, both Adult D and her partner were offered a short term placement in the Homeless Assessment Resettlement Provision (HARP) which was designed to accommodate individuals and couples who had been rough sleeping and explore resettlement options.

In February 2019, she went into hospital and it was expected that she would have help into other support from there. However, she ended up homeless until Noah helped her back into accommodation in April 2019. She was unable to be managed in one hotel as a result of her continence problems and this issue made it hard to find other accommodation for her. In August 2020, Adult D applied to the Council as a homeless person and was initially provided with temporary accommodation at a Luton hotel. In September 2020, she was rehoused in self-contained temporary accommodation on the ninth floor of a 9-storey block in Luton town centre. Consideration was being given to moving her to a safer environment but this was made difficult as a result of her continence problems.

Adult D was assessed by mental health services a number of times, and each time was assessed to have no acute mental health issues. However, Adult D had a history of problems with alcohol which seem to have pre-dated her move to England. In the last years of her life, there were clearly points at which she was physically dependent on alcohol. Her alcohol use had a significant impact on her life, nonetheless, she also expressed a strong desire to change throughout the period under review.

In the last year of her life, Adult D was clearly in physical and possibly mental decline. She was unwell with liver disease, was neglecting her personal hygiene, had continence problems, needed support with washing her clothes, was unable to manage her money, and was at risk of falls. There were also repeated concerns about her memory, possibly as a result of falls and seizures, but also possibly as a result of alcohol related brain damage.

Adult D was known to have had two partners while living in Luton, with whom she had fluctuating relationships. She was very vulnerable and was subjected to domestic abuse by, at least, the second of these partners and possibly both. She appears to have been the victim of other assaults and exploitation. Her partner was effectively banned from her accommodation, but still visited her in the last months of her life. However, she made a decision not to press charges or give evidence against the perpetrators because, she explained, she cared for them and did not want them to get into trouble. Therefore, no prosecutions ever resulted from this abuse and there was felt to be insufficient evidence for a "victimless" prosecution.

5. Adult D's engagement with services from 2018 onwards

Nothing was provided to the author about Adult D's engagement with services in the period before she arrived in Luton; and, as far as is known, local services were generally unaware of the details of Adult D's engagement with health, social care or criminal justice services prior to her arrival in Luton. The exception to this is her medical records which indicate that she had previously had medical help with anxiety, non-alcohol related liver problems and an alcohol withdrawal-induced seizure. However, she had considerable involvement with services in the 2-3 years before her death.

There are 10 entries in Police records concerning her between 2018 and her death. In each case, she is either the victim or a missing person. The majority of these relate to domestic abuse, but also include other assaults and robbery.

She had six contacts with East London Foundation Trust who provide mental health service in the area. These were either with psychiatric liaison staff or the nurse in the Rough Sleeper Initiative. All of these contacts were of limited duration and at no point was Adult D suspected of having, or diagnosed with, a mental disorder.

Luton and Dunstable University Hospital Trust have 33 entries in their records for Adult D between April 2018 and her death. Most of these are attendances at A&E and relate to intoxication and seizures (3 occasions). There is also mention of an endoscopy. However, in the latter part of 2020, the entries in the notes begin to focus on safeguarding meetings.

Adult Social Care received 10 safeguarding referrals concerning Adult D. Two of these were in 2018, three in 2019, but five were in 2020: giving a sense of her increasing vulnerability over time.

The safeguarding referrals came from a variety of agencies including the Ambulance Service, Noah, Housing, the Hospital, the Police and Keystage Housing. These concerns are usually the result of Adult D being found in a vulnerable situation e.g. in public with a head injury, or concerns about abuse or domestic abuse. Most of these referrals did not progress to a Section 42 enquiry as it was felt that she already had all the right agencies working with her. No section 9 assessment of needs for care and support was undertaken during the period under review.

Her major needs were her problems with alcohol, domestic abuse and housing. These led to extensive engagement with Noah, Resolutions and housing services.

Noah worked with Adult D intensively. The chronology of their involvement with her runs to 97 closely typed pages and has well over 500 entries from August 2017 until her death. One worker in particular, engaged well with Adult D and worked tirelessly to support her and improve the quality of her life. This included finding her a job, supporting her to find accommodation and helping her to engage with other agencies. Adult D's brother was particularly positive about the help that this worker had provided to his sister.

A key part of this support was referral to Resolutions. As with Noah, Resolutions had extensive contact. They provided a chronology of contact which ran to 130 pages and had between 200 and 300 entries. These contacts fall into two main periods of contact: July 2018 – March 2019 and July 2020 until her death. The first period was characterised by poor engagement with multiple missed appointments. The second period is focused on the efforts to complete a detoxification which was still awaited at the time of her death.

A key theme of Adult D's life was the appropriateness of her accommodation. She received help and accommodation via the Council Housing Solutions team and the Rough Sleepers' initiative in the second half of 2020, from Keystage Housing in the winter of 2019 and Noah supported her with finding accommodation in 2019.

6. Analysis

Adult D lived in Luton for just three years and little would have been known about her life prior to her arrival. Nonetheless much of the care and support she received from local agencies was very positive. The work of Noah, in particular, was a model of good practice. However, her untimely death does highlight issues from which lessons can be learned to improve local practice.

This report considers the care and management of Adult D across eight main themes.

- Alcohol misuse
- Multi-agency management
- Escalation
- Safeguarding
- Mental Capacity
- Abuse and domestic abuse
- Housing and homelessness
- Head injury

Of these, alcohol misuse is the main focus because it was almost certainly the most destructive element of her life and the one which, in part at least, prevented her from addressing the other serious problems that she faced.

7. Alcohol misuse

7.1 Working with high impact and change resistant drinkers

Adult D is an individual with her own unique characteristics and life history; but she is also representative of a group of clients who are featuring in a significant number of SARs[1] - people with chronic alcohol problems but also multiple exclusion, homelessness and possible mental health problems (in her case possible cognitive impairment). This group of clients present significant problems for various agencies. They make heavy unplanned use of services, but fail to engage or follow through on agreed actions and at times present in serious, possibly life-threatening, crisis.

Addressing the alcohol problems of Adult D will require a number of steps:

- Identifying that she is someone who needs alcohol interventions
- Ensuring that there is no stigma towards her as a result of her alcohol use and that professionals understand the barriers that she may face in attempting to change (e.g. cognitive impairment)
- Ensuring that alcohol services are available and, in particular, services that will recognise that she will need a response that is different from the standard pathway offered to people with alcohol problems
- Ensuring that an assertive outreach approach is used with her
- Ensuring that there is a multi-agency approach to her needs
- Ensuring that there is access to detoxification and residential rehabilitation when needed
- Ensuring that workers consider the use of legal frameworks such as the Care Act or Mental Capacity Act when appropriate
- Ensuring that there is an escalation route for clients who still pose a significant problem.

To a large extent, the local response matched these standards. Agencies were certainly aware that Adult D had an alcohol problem, alcohol services were available to meet that need and, more importantly, both assertive outreach and multi-agency management were features of the work with her, although these were not driven by the alcohol services. The assertive approach used by Noah highlights the effectiveness of this approach in engaging clients and bringing them to the point where change is possible. On the other hand, although multi-agency management was a feature of her care, problems were identified with this process which are explored in section 8.

It is possible that negative attitudes to her drinking may have impacted on both the use of safeguarding and consideration of her mental capacity - these will also be discussed later (section 11 & 12); but there is little evidence that workers' attitudes significantly impeded her care.

However, the chronology and IMRs highlight two themes related to the response to her alcohol problem which should be considered:

[1] 25% of recent SARs according to both Professor Michael Preston-Shoot's review of SARs Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 (local.gov.uk) and Alcohol Change UK's Learning from Tragedies Learning from tragedies: an analysis of alcohol-related Safeguarding Adult Reviews published in 2017 | Alcohol Change UK

- The general response to hard / reluctant to engage clients;
- The pathway into detoxification and residential rehabilitation.

The latter is the more important of these two.

7.2 Working with dependent drinkers - general

Much positive work was done with Adult D by local alcohol services. Resolution's Hospital Liaison Recovery Worker within Luton & Dunstable hospital was a useful focal point for work with Adult D when she was in the hospital. Adult D was also open to Resolutions for two substantial periods. The first period was characterised by challenges with engaging her into one to one interventions. Nonetheless, Resolutions kept the case open for a considerable period of time. However, this intervention highlighted three concerns:

- The case was very abruptly closed in March 2020 – the Resolutions IMR comments that there is: *No documentation around if a manager signed adult D's discharge off. Resolutions discharge process was not followed. Team Leaders should sign all discharges off to ensure it is a safe discharge and all relevant processes have been followed.*
- The challenges of engaging Adult D during this first period underline the limited options available to Resolutions for responding to these difficult to engage clients.
- HARP sent an email to her support worker at Resolutions on 6th February to request an urgent appointment with Resolutions, however, the next available appointment for Adult D was set for 26th February 2019. The Resolutions IMR acknowledges that the process around this decision was inappropriate with a woman presenting the level of risk that she presented.

At the end of January 2020, a referral was received by Resolutions from the hospital liaison team. Limited efforts were made to contact Adult D and was then not pursued further. This is acknowledged in the IMR as *a missed opportunity to engage* her.

It is positive to note that in September 2021, Resolutions developed the High Intensity Team. This provides assertive engagement for service users that the service finds it challenging to engage in structured community drug and alcohol treatment. The Team holds smaller caseloads to allow for more intensive engagement with service users who may experience domestic violence, sexual exploitation and more. Lastly, the Designated Safeguarding Lead has introduced a monthly safeguarding meeting in January 2021 to provide a multi-disciplinary space to ensure information is acted upon appropriately.

It should also be noted that Adult D was reported to be positive about the psycho-social work that was provided to her (in Polish) by Resolutions and was reported to have enjoyed the engagement with her worker.

Her second period of engagement with Resolutions began in July 2020 and ended with her death. The main issue in this period is Adult D's access to detoxification which is addressed in the next section.

7.3 Detoxification and residential rehabilitation

The key issue in the response to Adult D's alcohol problem is the adequacy of the pathway into detoxification and, possibly, residential rehabilitation (the latter is not something Adult D requested). This report would argue that given Adult D's dependence on alcohol, her physical health problems and her evident vulnerability, a pathway from inpatient detoxification into residential rehabilitation would appear to have been the best route for her in the last months of her life.

Adult D herself was clear, when asked by a social worker, how best her situation could be made better, that her first and very important priority was to undergo detoxification. In 2018 Adult D was on a pathway to detoxification which appears to have involved reduction in the community. However, Resolution's notes do not clarify the outcome of that detoxification.

In the months prior to her death she was certainly on a pathway that should have led to an inpatient detoxification; however, it is understood that she wasn't on a pathway to residential rehabilitation: the detox was seen as a breathing space and the expectation was that she would continue to be supported to settle into stable accommodation. It is understood that professionals were considering a move further out of town if Adult D successfully completed her detoxification.

NICE guidance suggests that Adult D required an inpatient detoxification. It indicates that clinicians should *consider inpatient or residential assisted withdrawal if a service user meets one or more of the following criteria. They: • drink over 30 units of alcohol per day • have a score of more than 30 on the SADQ • have a history of epilepsy, or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes… (have) a significant learning disability or cognitive impairment…Consider a lower threshold for inpatient or residential assisted withdrawal in vulnerable groups, for example, homeless and older people.*[1] At the very least Adult D met the criteria for inpatient detoxification as a result of seizures, it is also arguable that her housing was unsuitable and she may have met the criteria due to cognitive impairment and/or liver disease.

However, there are repeated concerns about:

- the time it took Resolutions to organise an inpatient detoxification for Adult D and
- the complexity of the process involved.

In addition the pathway seemed to require reduction of her drinking in the community.

This process began in autumn of 2020 and in October and November concerns are expressed by Noah and the Council about the length of time that it was taking for Adult D to be detoxified. At that point there were concerns that this could take until January or February 2021. The detoxification had not taken place by the time she died. One of the IMRs highlighted the same concern about lengthy detoxification pathways with another client.

Another IMRs states that: *The alcohol treatment programme itself was very difficult to understand and follow even for professionals working with Adult D. There was an expectation for Adult D to be abstinent almost as a show or willingness to change put*

upon Adult D, and this she could not manage. At one point, in one of the meetings professionals asked for clarification of the local Alcohol Treatment methodology...It was confusing because most professionals believed that abstinence would have been the outcome following detox and rehab and not a pre-requisite for detox/rehab. This is an area that all partners agreed we need a review, open discussion and change.

Resolutions have highlighted that Covid 19 restrictions may have played a part in restricting access to this pathway. The Resolutions notes also highlight some uncertainty about what detoxification pathway should have been pursued – community or inpatient; Resolutions own records suggest that Adult D was someone who would need an inpatient detoxification according to the NICE guidance. Yet for most of the autumn of 2020 a community-based alcohol reduction plan is pursued. In December 2020, Adult D may have had a fit/seizure and a Resolutions recovery worker questioned whether this was the result of the slow alcohol reduction programme. This seems to have resulted in her GP submitting an urgent referral form to the hospital for an inpatient detoxification.

Resolutions have highlighted other issues that may have impacted on this pathway – a lack of clarity about how much she was drinking and occasional ambivalence from Adult D about whether she wanted detoxification and rehabilitation. For example, there was an occasion when Adult D said that she no longer wanted detoxification; however one of the IMRs comments that *"this is likely to be because she was very frustrated with the excessive delays and was giving up on hope in the process."* The Resolutions IMR acknowledges that: *It would have been beneficial to breathalyse Adult D frequently to get a better understanding of the volume she was drinking due to memory concerns and incontinence. Resolutions ability to breathalyse frequently was hindered due to COVID 19 and government restrictions.*

It is important to recognise that detoxification and rehabilitation are not a "magic bullet" that will solve her problems. The proposed detoxification may have simply led to another relapse. It also needs to be acknowledged that due to "kindling"[2] repeated detoxification may have a negative impact on the drinker physically or cognitively. For that reason alcohol services may be reluctant to rush someone into a detoxification.

However, given Adult D's physical health, her evident vulnerability and the challenges that she is going to face attempting to change in the community, it is hard to argue that anything other than an inpatient detoxification was indicated. The failure to organise the detoxification in the months before her death, does suggest a problem in this pathway that needs to be reviewed.

Nonetheless, a detoxification is futile, if not unhelpful, without a robust care plan following the intervention. It is surprising to note that there is no evidence that consideration was being given to a pathway into residential rehabilitation. There may have been reasons for this – the impact of Covid on the availability of rehabilitation places, or the disinterest on the part of Adult D. Whatever the reason, Adult D's situation is a reminder of the importance of considering residential rehabilitation as an option and the importance of having an accessible pathway to such services, particularly post detoxification.

[2] Alcohol misuse - Risks - NHS (www.nhs.uk)

8. Multi-agency management

Best practice with complex dependent drinkers would suggest the need for multi-agency management. In the care of Adult D, there was good evidence of organisations working together generally, especially Housing and NOAH.

Four professionals meetings focused on safeguarding Adult D were held between September and December 2020. Adult D was also discussed at the VARAC meeting in November and December and these meetings endorsed the need for ongoing inter-agency working.

This is positive but there was concern about the effectiveness of the professionals' meetings. One IMR commented that the meetings *lacked bite... there was a lack of accountability held to the actions that partnership agencies agreed at meetings….there was a lack of understanding regarding safeguarding meetings their scope and purpose… the meetings were treated as a professional meeting to support a client into the detox pathway - not as a meeting to safeguard a painfully thin and fragile woman with alcohol issues and who was experiencing abuse on a daily basis who needed a detox to try to break the shackles of her abusers.*

This highlights that simply holding multi-agency meetings is not enough, they have to be forums which can deliver action. They have to be places where:

- colleagues can professionally challenge each other
- the membership is sufficiently senior to drive action and
- there is a means for escalating concerns about failures in the care pathway.

The lack of these features was specifically commented on in one of the IMRs and in the practitioners' workshop. The Rough Sleepers team IMR highlighted that there was a reluctance to challenge partnership agencies at these meetings and that there was a lack of accountability in these meetings. There were also issues about the consistency and seniority of staff attending the meeting and the non-attendance of some agencies.

The practitioners' workshop was clear that these multi-agency meetings would have benefited significantly from more senior management involvement, the ability to escalate concerns, more clarity on roles and professionals feeling able to challenge one another over gaps in the response provided.

Multi-agency management is an important part of working with complex clients; however, for it to be effective it will require practitioners to be trained to make the most of the opportunity it provides and to understand their roles in the group. It cannot simply be assumed that bringing professionals together in a group will be effective without a supporting framework.

A second question is whether Luton could benefit from having a specialist multi-agency group that focuses on this client group. This would provide a standing, expert group for managing this client group rather than require 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.

Decisions on the future structure of multi-agency management in Luton will require a mapping of existing multi-agency groups and a decision on an escalation pathway (see below).

9. Escalation

It is possible that, even if services were working effectively with assertive outreach available, good multi-agency working and a smooth pathway into detoxification and/or rehabilitation, Adult D would still not have moved forward.

In such cases there need to be robust escalation pathways in place, including processes which can effectively challenge agencies to try more creative approaches to managing complex and potentially costly clients. Escalation would encompass both:

- use of legal frameworks such as the Care Act and Mental Capacity Act; and
- further escalation to a more senior multi agency group;

The use of legal frameworks will be considered in section 10 and 11 below.

With regard to other forms of escalation, Plymouth City Council has set up a very senior body, the Creative Solutions forum, with the aim of providing: *an additional multi-agency, multi-disciplinary response, which can agree bespoke packages of care, enable better risk sharing and risk management between agencies, and facilitate better outcomes for people than could be achieved with 'usual care'.* It is reserved for *cases with high complexity and high risk where a single agency approach is not adequate to meet need*. It is interesting to note that in its description of itself the group provides a case study of a typical client who is *often found inebriated in public and at high risk of harm and risk from others, frequent call outs by emergency services, multiple self-discharges from ED and hospital, continual non-engagement with services.*[2] It is possible that such a group would be beneficial in Luton; however, at the practitioners' event it was suggested that this role was played by the local Risk Enablement Panel.

Escalation will also be facilitated by timescales for a response. Any decision on escalation to a more senior multi agency group should include a decision on such timeframes.

10. The Care Act and Safeguarding

Dependent drinkers are covered by both the general assessment and care planning powers in the Care Act (section 9), and by the safeguarding powers (section 42). In particular, people with care and support needs who self-neglect as a result of their chronic drinking may require safeguarding under the Care Act. This is true whether the person lacks mental capacity or not and whether or not the care and support needs are being met.

However, the general (and national) problem with safeguarding these clients is that, as the Andrew SAR (Waltham Forest) highlights: *It is not routine or shared practice to accept that chronic alcohol misuse is a form of self-neglect...This directly affects the response by professionals.* This belief needs to be challenged; self-neglect by dependent drinkers is covered by the Care Act in the same way it is for other client groups.

Between April 2018 and October 2020 there were 10 safeguarding referrals for Adult D. For example in April 2018 the Ambulance Service made a referral following her being found *with a head injury in an alley.* In July 2018, the Ambulance Service made a referral following her being found intoxicated on a bench. Referrals were also received from Noah, the Police and the Hospital. Perhaps more importantly the number of safeguarding referrals was escalating over time, so that there were five in 2020 – the same number as in the two previous years.

The majority of these referrals did not progress to a Section 42 enquiry. The two safeguarding referrals raised in 2018 – by the Police and Ambulance Service received Level of Response 2 - a level of risk that could be managed via non-statutory interventions. The same applied to the three safeguarding referrals raised in 2019. In each case, the referral was considered and it was acknowledged that a number of organisations were already involved, raising questions about whether Adult Social Care's involvement would have added anything new.

Of the five safeguarding referrals raised between February 2020 and October 2020, only the last referral in October 2020 proceeded to a Section 42 enquiry and was allocated to a social worker.

The question is whether the decision not to progress the majority of these referrals to a Section 42 enquiry is justifiable. At this distance in time, it is impossible to argue that a different approach should have been taken at any one particular point. The key question is whether decisions were simply being taken in the context of the current referral or whether staff were giving consideration to the escalating pattern of referrals? Adult Social Care's IMR acknowledged the need to consider this issue.

It will be important to ensure that in any decisions about safeguarding, consideration is given to the person's ongoing history and pattern of referrals and that cumulative referrals trigger a different response to that which a similar referral would have received in isolation.

Consideration also needs to be given to whether safeguarding referrals should have been made at other points. It is positive that a range or agencies made referrals about her including the Ambulance Service, the Police, Housing, HARP, the Hospital and Noah. However, Resolutions acknowledge that there were opportunities for recovery workers to refer Adult D to Adult Social Care, in accordance with their internal policy, which were not taken.

Adult Social Care also acknowledge that there were two missed opportunities where a Section 9 assessment of her care and support needs could have been completed (e.g. on discharge from hospital). Given her situation in the last few months of her life it is likely that this would have evidenced eligible needs. The Adult Social Care IMR

acknowledges that: *In the continued absence of receiving a timely assessment she continued getting support from her social circle that was putting her at very high risk. Having care needs met through statutory services would have increased the number of professional visits to her home which were minimal and thus raised awareness of the reality of the abuse she was suffering. It could have also helped evidence the need for a move to safer accommodation.*

11. Mental Capacity Act

Various agencies comment on Adult D's mental capacity and on all but one occasion (see Noah's comments below) she was assumed to have capacity. The Adult Social Care IMR comments that: *The first principle of the mental capacity Act 2005 clearly states the assumption of capacity. An assessment would need to be carried out where there may be an 'impairment of or disturbance in a person's mind or brain' affecting their ability to make particular decisions. All professionals that worked with Adult D worked with the assumption that she had mental capacity to make decisions, she understood concerns pertaining to her lifestyle and unhealthy relationships. No single agency carried out a mental capacity assessment and or raised concerns pertaining to mental capacity. It has been reported in the professional meeting held on the 5/1/21 that all professionals agreed that Adult D had the capacity to make her own decisions.*

This raises two questions:

- To what extent was Adult D's mental capacity assumed rather than assessed?
- She may have had the capacity to <u>make</u> decisions; but did she have the capacity to <u>execute</u> those decisions?

At none of the points where Adult D's mental capacity is commented on is there any evidence that these statements are based on a robust assessment. For example:

- *Resolutions keyworker <u>reported</u> that Adult D has capacity and understand what she is doing.*
- *It was…documented in her (hospital) notes 'patient unsure of the above, nil symptoms currently, nil red flags, admits to feeling low, fleeting suicidal thoughts, nil ideations or plans, depression symptoms, tearful, wants help for this and "someone to listen", had 2-3 beers, does not appear to be heavily intoxicated currently, <u>coherent and has capacity</u>'.*
- *Adult D was not open to Adult Social Care; previous safeguarding concerns were received in January and February 2019. These were screened out, as Adult D was <u>deemed</u> to have capacity to make informed decisions about her relationship.*
- *In the general hospital records for January 2020 she is "<u>Noted</u> to have capacity".*

At the very least, the basis on which statements about capacity are made should always be recorded in the notes.

A more detailed note on the June 2021 case conference (after her death) provides a more nuanced picture of her capacity. *Adult D's capacity was not questioned by the professional's apart from Noah as they believed that she did not have the capacity to make a decision about her safety but could make daily decisions about her care. In*

Mental Capacity Act 2005, Principle 1, S4, A person is not to be treated as unable to make a decision merely because he makes an unwise decision. This was Adult D still being friends with those who abused her repeatedly whether, this was because of loneliness or she wanted to protect them it was a decision Adult D arrived at with the same evidence as we professionals had."

Again this raises questions about the basis of this view of her capacity. It also highlights that Noah are questioning this assumption of mental capacity.

Dependent drinkers are covered by the Mental Capacity Act. Stage 1 of the two-stage test of mental capacity requires proof that the person has an impairment of the mind or brain.[3] These impairments include *the symptoms of alcohol or drug use*.[4]

The second stage tests whether a person can:
1. understand information about the decision to be made or
2. retain that information in their mind or
3. use or weigh that information as part of the decision-making process, or
4. communicate their decision. [5]

A chronic, dependent drinker could fail any of these four criteria. For example, someone with cognitive impairment might not meet either of the first two criteria. However, with Adult D the more relevant issue may be the third criteria: can she *use* information in a decision-making process. The MCA Code of Practice provides a useful parallel for the situation of the dependent drinker. The Code says: *a person with the eating disorder anorexia nervosa may understand information about the consequences of not eating. But their compulsion not to eat might be too strong for them to ignore.*[6] [7]

This is a situation that will be commonplace with many dependent drinkers: their compulsion to drink means that they are unable to use information that they are given about the impact of their dependency, even if they understand and retain it. The Teesside Carol SAR talks about the need to look at a dependent drinker's "executive capacity" as well as their "decisional capacity". Can someone both take a decision and put it into effect (i.e. use the information)? This will necessitate a long-term view when assessing capacity with someone like Adult D.

Assessing capacity in dependent drinkers is complex and should not be subject to simplistic judgements. Decisions may require time, multi-agency discussion and professional challenge.

The Code of Practice supports this stating that: *Information about decisions the person has made, based on a lack of understanding of risks or inability to weigh up the information, can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else.*[8] This approach has also been supported by SCIE (the Social Care Institute of Excellence).

In addition, it should be remembered that the Code of Practice comments that:

2.11 There may be cause for concern if somebody:

> • *repeatedly makes unwise decisions that put them at significant risk of harm or exploitation...These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation…*[9]

Even if Adult D did have the capacity to care for herself, the Code suggests that professionals seeing this repetitive behaviour should certainly have explored what lay behind this pattern.

Above all there are a number of factors in Adult D's presentation that raise questions about whether she really did have mental capacity. Her advanced liver damage could have had an effect on her cognition, as could repeated head injuries and fits. She may have been subject to undue external influences from other people which impacted on her ability to make choices. She was also intoxicated much of the time which would have impacted on her capacity.

It has to be acknowledged that the Mental Capacity Act is not an easy fit for people like Adult D. The guidance on Act (the Code of Practice) contains only three references to alcohol which makes it challenging to apply. However, Adult D required more than simple assumptions of capacity and could have benefited from a more considered approach to the legislation and its application.

12. Abuse and domestic abuse

Adult D was subject to domestic abuse / intimate partner violence and probably abuse or exploitation from other people. However, there are gaps in the response to this abuse, but also positive reflections from agencies on the need for an improved response.

Most of the concern about domestic abuse centres on the man who was her partner for most of the last two years of her life. However, there is also evidence of abuse by a previous partner.

In July 2018 Resolutions received a telephone call from Adult D saying that she was not allowed out by her partner and that was why she had not attended an appointment with the service. This did not lead to concerns or action about coercion and control. Indeed a further call was made to her partner as the means of contacting Adult D. This has been acknowledged by the organisation and a new pathway has been put in place.

In January 2019, she was assaulted by her partner while in Keystage Housing. This was identified by staff and appropriate steps taken to involve the Police, support her, and provide her with accommodation on a women's only wing of the facility. However, Adult D was unwilling to support further action against her partner and she was unable to be accommodated in a refuge because at that time she had no recourse to public funds.

There were discussions about whether the Police should have considered using a "victimless" approach to a prosecution at this and other points, but in the practitioners' event it was clearly stated that this was not possible because of the lack of other evidence. This highlights a training need. Practitioners need to understand what

evidence would support such a prosecution, how that can be recorded and reported in a way that supports the Police's efforts to undertake a prosecution.

At the end of February 2019, HARP staff members said that they had seen Adult D with bruises on her face which she refused to talk about. She was still seeing her partner daily. This led to HARP submitting a safeguarding referral.

In February 2020 a safeguarding referral was received related to domestic abuse and self-neglect. Adult D disclosed that her partner was emotionally and financially abusing her, and that in order to cope with the abuse she was abusing alcohol.

In July 2020**,** she was assaulted by her partner again and was moved to a hotel by Noah. A safeguarding concern was raised as a result.

Concern about her safety continued when she was in her last placement. Noah staff had significant concerns about Adult D being exploited and this concern was shared by the Rough Sleepers team. In September 2020, a safeguarding referral was raised by her Noah keyworker. She had left her partner, but had found another man who was taking advantage of her. She was found with bruising to her face and eyes, but couldn't recall how it had happened. Two men in her property were known to the Police for exploiting other people and there was concern about possible cuckooing.

Addressing the abuse against Adult D was complicated because, at times, it was hard to determine whether injuries were the result of violence or drunken accidents. However, it does seem that too little action was taken to address the abuse that Adult D experienced:

- The Rough Sleepers Project IMR suggests that a MARAC referral would have been appropriate for Adult D, but this never happened.
- Consideration was given to seeking an injunction against her partner coming to her property, but this did not happen – possibly for practical reasons (including that he should not have been visiting anyway as a result of Covid restrictions).
- Adult D was referred to Luton All Women's Centre. Telephone communication with Adult D was not possible, therefore the worker was unable to establish her views and wishes.
- In April 2020 the Police completed a DARA (a new form of DASH involving less questions) and adult risk assessments. However, there was no further action. The Police IMR acknowledges that an opportunity for referral was missed.
- Adult D would have benefited from receiving support through an Independent Domestic Violence Advocate (IDVA). This would have supported the wider services by providing support and advice around domestic abuse to professionals as well as Adult D. This did not happen.
- Adult D's case was discussed at the VARAC (Vulnerable Adults Risk Assessment Conference) meeting in November 2020. However, the case was not accepted at VARAC. This was a missed opportunity for professionals to be involved.

The IMR goes on to question whether the abuse Adult D experienced was seen as part of the street culture she found herself in and, therefore, not treated with sufficient seriousness. Noah, the Rough Sleepers team and Resolutions all recognise the need

for further training on the management of domestic abuse, specifically in the context of homeless and marginally housed communities.

13. Head injury

The IMRs make repeated reference to Adult D's poor memory, she also experienced repeated head injuries and had seizures which could impair cognition. The section above on domestic abuse highlights a number of injuries to her head. In addition:

- In April 2018, she was found located in an alley-way with head injuries
- In October 2018 she was admitted to hospital for a head injury following a seizure
- In August 2020 she went to hospital with a head injury following intoxication
- In September 2020 she sustained injuries to her head following a robbery.

Agencies were concerned that this was impacting on her ability to manage herself and recover from her alcohol misuse. For example, the Resolutions IMR comments that during Adult D's second episode of treatment, it would have been beneficial for Adult D to have accessed support from the local Memory Clinic. If a diagnosis of alcohol related brain damage had been made, this would have provided opportunities to access wider support services. She was referred to the service but they required her to be abstinent for three months prior to assessment and this was clearly not possible for Adult D. Resolutions rightly comment that this should have been escalated to lead consultants or the service manager.

Accurate understanding of her head injuries would have:

- been an important element in understanding her mental capacity;
- supported the services working with Adult D to have made appropriate adjustments in the way they worked with her to accommodate her cognition;
- focused services on the need for inpatient detoxification and residential rehabilitation.

However, the expectation that she will be sober for three months before she can be assessed is unrealistic. Consideration needs to be given to whether there are ways in which the extent of brain injury in clients like Adult D can be better understood without the expectation of three months sobriety.

It should also be noted that conditions such as liver disease can impair mental functioning and add to the problems that she will be experiencing.

14. Housing and homelessness

Adult D's housing was a problem throughout her time in Luton. At times she was street homeless. On one occasion she had to leave a hotel because of the problems of managing her continence problems. There were problems in other properties because of the people she associated with or because of violence from her partner. Her housing was all the more problematic because until mid-2020 she had no recourse to public funds.

Nonetheless local agencies, Noah, Housing Options, local Housing Associations, and the Rough Sleepers Initiative, did offer her real support. In early 2019 she moved into the HARP winter accommodation and they were flexible enough to offer her women's only accommodation following an assault by her partner. In August 2020, Adult D left a local hotel and applied to the Council as a homeless person and was initially provided with temporary accommodation in a Bed & Breakfast. In September 2020, she was rehoused in self-contained temporary accommodation on the ninth floor of a 9-storey block in the town centre.

Questions were raised during the review process as to whether Adult D's accommodation in the flats was appropriate for her. The location in the town centre made it easier for her to access NOAH and Resolutions. However, the location was ultimately not safe for her because she was vulnerable to people, including her partner, coming in and misusing her property and abusing her.

As a result of a safeguarding referral, there were discussions between Safeguarding and the Housing Officer regarding these concerns and other accommodation options. However, the only properties that were mentioned as a move on option would not accept Adult D due to her alcohol related continence issues

In particular, it was noted by the Council's Housing Team that they do not have ready access to specialist accommodation with on-site support, which Adult D would have benefited from. This type of accommodation does not exist within the Council's housing stock and represents a gap in local service provision.

15. The impact of Covid – a note

The last nine months of Adult D's life were spent under the restrictions imposed due to Covid. This certainly impacted on her relationship and engagement with some agencies e.g. the accessibility of appointments with her GP or Resolutions. Nonetheless, agencies such as Noah, the GP and various housing services continued to work with her face to face. It is hard to make a direct link between the Covid restrictions and her death; nonetheless, the pressures on services at this time do need to be acknowledged.

16. The need for national legislative change

The care of Adult D raises a very different question. Does England need a new legislative framework for managing chronic dependent drinkers?

Some simple statistics highlight the problem:

- 25% of SARs feature people with significant alcohol problems *(National SAR Analysis: April 2017-March 2019 (2020)*

But:

- The Code of Practice on the MCA mentions alcohol just three times.
- The Guidance on the Care Act in England mentions alcohol just twice.

Other Westernised countries do have legislation which is specific to this client group and allows the compelled, protective, detention of dependent drinkers like MS. In some jurisdictions this is called “civil commitment” (e.g. USA). [10] [11] [12] Indeed Article 5 of the European Convention on Human Rights specifically recognises this possibility.[13] Such legislation might have provided a framework within which Adult D’s needs could have been managed.

Three options exist for addressing this gap:

- Revised guidance / code of practice or specific guidance as per the CQC guidance on the Mental Health Act & Eating Disorders
- Revisions to the existing legislation
- New legislation as per other countries

In the short term, it is most realistic to look for a change to the guidance on the legislation. In particular, clarification about how the Mental Capacity Act and the Care Act should be applied to this client group including case study examples. This would cover issues such as “executive capacity” or how the self-neglect provisions of the Care Act apply to dependent drinkers.

The Safeguarding Adults Board or other groups in Luton may wish to consider lobbying for, at the least, better guidance on how to use the existing legislation most effectively with this client group or even renewed legislation.

17. Findings

- Adult D’s care highlights the need to ensure that specialist alcohol services have a pathway to manage clients who are going to find it hard to engage with standard one to one appointment and group structures. These difficult or reluctant to engage clients will require a more flexible and assertive response. Adult D was fortunate to receive such a response from Noah; however, it is important to ensure that alcohol services are commissioned to pursue the same approach. Resolutions acknowledged gaps in this pathway.

- According to the standards set out in NICE guidance, Adult D required an inpatient detoxification. However, Resolutions were both unable to organise this in the months before her death, and seemed to be suggesting that someone with a history of alcohol-related seizures should pursue a community-based alcohol reduction programme. This suggests a problem in this pathway that needs to be reviewed.

- Adult D’s situation is a reminder of the importance of considering residential rehabilitation as an option and the importance of having an accessible pathway to residential rehabilitation.

- It was positive that multi-agency management meetings were held to discuss Adult D. However, her care highlights that simply holding multi-agency meetings is not enough, they have to be forums which can deliver action. They have to be forums where:
    - colleagues can professionally challenge each other;

  - the membership is sufficiently senior to drive action; and
  - there is a means for escalating concerns about failures in the care pathway.

- Training would be useful on enabling participants to make effective use of multi-agency meetings and on the most effective way to chair and manage these meetings.

- Local commissioners and strategic leads may wish to consider setting up a multi-agency group (or nominating an existing group) to manage chronic dependent drinkers. This will require mapping of existing multi-agency groups and their inter-relations.

- The challenges of caring for Adult D highlight the need for robust escalation pathways (including timeframes) which can support agencies to try more creative approaches to managing complex and potentially costly clients. One model is provided by the Plymouth Creative Solutions Group.

- Adult D was subject to multiple safeguarding referrals. However, only one of these progressed to a Section 42 enquiry. A key question raised by this review, but also acknowledged by the Safeguarding Team, is whether safeguarding decisions are simply being taken in the context of the current referral or whether staff are giving consideration to the escalating pattern of referrals?

- Mental capacity decisions need to be based on a full and appropriate assessment, not simply on assumptions. It is not clear that this was the case with Adult D.

- Mental capacity assessments with clients like Adult D need to consider executive capacity. They need to consider not only whether Adult D can take a decision but also whether she can execute that decision. The compulsion associated with alcohol dependency, poor impulse control resulting from brain injury and coercion and control from others may all impact on her ability to execute decisions.

- At the very least, the basis on which statements about capacity are made should always be recorded in the notes.

- Adult D was a victim of domestic abuse, intimate partner violence and other abuse. The IMRs highlight gaps in the response to this abuse; in particular the response to domestic violence in the context of street homeless and marginally housed communities. Agencies such as Noah, the Rough Sleepers team and Resolutions all recognise the need for further training on the management of domestic abuse, specifically in the context of homeless and marginally housed communities.

- The inability to secure a “victimless” prosecution highlights that practitioners will need to understand what evidence would support such a prosecution, how that

can be recorded and reported in a way that supports the Police's efforts to undertake a prosecution.

- Significant work was done by local agencies to accommodate Adult D. However, it was noted by the Council's Housing Team that they do not have ready access to specialist accommodation with on-site support, which Adult D would have benefited from. This type of accommodation does not exist within the Council's housing stock and represents a gap in local service provision. Such a development may require a joint approach across Housing, Adult Social Care and specialist providers.

- Considerable concern was expressed about Adult D's cognition as a result of a long-standing pattern of repeated head injuries. It was impossible to secure a diagnosis for this because of her ongoing drinking. Therefore, consideration needs to be given to whether there are ways in which the extent of brain injury in clients like Adult D can be understood without the expectation of three months sobriety.

- Those who commission and plan the development of alcohol treatment services may wish to consider lobbying national government for either improved guidance on using the Care Act, Mental Capacity Act and the Mental Health Act with this complex client group, or new legislation to better meet their needs.

18. Good practice

Despite the tragic outcome of Adult D's life, her care does highlight some very good practice.

- Noah's work conformed to best possible practice with this client group: an approach based on assertive, persistent and consistent engagement and efforts at multi-agency management with the aim of building a team around the person. Indeed as one of the IMRs commented: *The support and commitment from NOAH services was extraordinary. They continued to provide high levels of service despite the COVID restrictions that were in place at the time. Her Polish-speaking worker clearly cared passionately for the wellbeing of Adult D. She saw her on a near daily basis and worked with her in a kind and caring way.* This is worthy of real praise.

- Resolutions provided psychosocial work in Polish. Adult D enjoyed this engagement with her worker. Again this is good practice.

- Other agencies such as the Rough Sleepers Team and Keystage Housing also seem to have made robust efforts to support Adult D.

19. Recommendations

Recommendation A

Substance misuse service commissioners and Resolutions, as the local substance misuse provider, should ensure that the specific needs and impacts of chronic, change resistant and dependent drinkers are identified in needs assessments, addressed in any future commissioning plans and addressed in internal service development plans. In particular, investment in assertive outreach capacity for this group of clients is required.

Recommendation B

Substance misuse service commissioners should review the local alcohol detoxification pathway to ensure that it is fit for purpose and adheres to NICE guidance. In particular, it should be flexible in its response to drinkers with complex presentations.

Recommendation C

Those who commission and plan the development of alcohol treatment services need to ensure that frontline staff consider residential rehabilitation as an option for clients and that it can be accessed without undue barriers. In particular, a path from inpatient to residential rehabilitation should be possible for complex clients.

Recommendation D

All appropriate frontline professionals (and their managers) require training on the application of the Mental Capacity Act to people who are dependent on alcohol. This should include a recognition of the role of executive capacity and, in particular, that the physical health impacts of drinking can affect cognition and impulse control and therefore mental capacity. It is important that this training includes lessons from this and other SARs and other serious case reviews.

Recommendation E

The SAB should ensure training is available to enable participants to make effective use of multi-agency meetings and on the most effective way to chair and manage these meetings. Simply holding multi-agency meetings is not enough, they have to be forums which can deliver action and where:

- colleagues can professionally challenge each other
- the membership is sufficiently senior to drive action and
- there is a means for escalating concerns about failures in the care pathway.

Recommendation F

The SAB should ensure that there are robust escalation pathways which can support agencies to try more creative approaches to managing complex and potentially costly

clients. The Plymouth Creative Solutions group offers a model. This will require a mapping of existing multi-agency groups and a decision on an escalation pathway including timeframes for a response to any escalation.

Recommendation G

The SAB should ensure that people experiencing domestic abuse in the context of homeless and marginally housed communities receives the same response as other people experiencing abuse.

Recommendation H

The SAB should ensure that practitioners across all relevant agencies receive training in how to support a “victimless” approach to a prosecution. Practitioners will need to understand what evidence would support such a prosecution, how that can be recorded and reported in a way that supports the Police’s efforts to undertake a prosecution.

Recommendation I

Housing Services and Adult Social Care should consider whether specialist accommodation with on-site support should be commissioned locally. This is likely to be from a specialist provider.

Recommendation J

The Clinical Commissioning Group need to consider whether there are ways in which the extent of brain injury or cognitive impairment in clients like Adult D can be understood without the expectation of three months sobriety.

Recommendation K

Those who commission and plan the development of alcohol treatment services may wish to consider lobbying national government for either improved guidance on using the Care Act, Mental Capacity Act and the Mental Health Act with this complex client group, or new legislation to better meet their needs.

Appendix 1 – Terms of reference

The Terms of Reference were set out as *Key Questions for Consideration* by the agencies involved. They were designed to act as prompts in considering the case.

- Did your agency have any information to suggest that Adult D was being abused or neglected, including domestic abuse? If so, was this information appropriately acted upon? Was work in the case consistent with agency and Luton SAB policy and procedures for protecting adults at risk and other relevant local policies and procedures?
- What were the key points or opportunities for risk assessment and decision making in this case in relation to Adult D? Do the assessments and decisions appear to have been reached in an informed and professional way?
- Does it appear that all legal options, including seeking legal advice where appropriate, were explored to safeguard Adult D?
- Where relevant, were appropriate Safeguarding Adults Plans (protection plans), risk assessments or care plans in place and were these plans implemented? Were there any factors present that prevented these plans being implemented successfully? Had review processes been complied with?
- When, and in what way, were Adult D or her family's wishes, feelings and views ascertained, considered and acted upon? Did action accord with the views expressed?
- Was practice sensitive to any protected characteristics of Adult D?
- Were senior managers, or other agencies and professionals, involved at points where they could have been?
- Are there any particular features of this case, or the issues surrounding the case, that you consider require further comment in respect of your agency's involvement?
- What are the lessons from this case for the way in which your agency works to protect adults at risk and promote their welfare?
- Are there any aspects of Luton SAB policy and procedures that need to be reviewed as a result of this case?
- Were appropriate steps taken to address her substance misuse?
- To what extent was there a persistent, creative, and flexible outreach approach to working with Adult D?
- Were appropriate steps taken to address any housing / homelessness issues?
- To what extent did consistent multi-agency management feature in her care?
- Was the potential impact of her physical health status on her mental well-being considered including head injuries, smoking, diet, nutritional status and weight?
- Are there any aspects of the case or agency involvement that are examples of strong practice?

[1] NICE - Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115) - 2021
[2] Microsoft Word - Social Care - Creative Solutions Forum - Plymouth.docx (councils.coop)
[3] Mental Capacity Act 2005 Code of Practice (4.11)
[4] Mental Capacity Act 2005 Code of Practice (4.12)
[5] Mental Capacity Act 2005 Code of Practice (4.14)
[6] Mental Capacity Act 2005 Code of Practice (4.22)

[7] See also: Clough B. - Anorexia, Capacity, And Best Interests: Developments in The Court of Protection Since The Mental Capacity Act 2005 - Medical Law Review, Vol. 24, No. 3, pp. 434–445. (Clough Identifies three cases regarding anorexia that went before the Court of Protection. In each case it was decided that the person with anorexia nervosa did lack capacity.)
[8] Mental Capacity Act 2005 Code of Practice (4.30)
[9] Mental Capacity Act 2005: *Code of Practice 2.11*
[10] http://www.emcdda.europa.eu/attachements.cfm/att_142550_EN_SE-NR2010.pdf
[11] http://www.legislation.govt.nz/act/public/2017/0004/latest/DLM6609057.html?search=ts_act%40bill%40regulation%40deemedreg_substance+addiction_resel_25_a&p=1
[12] http://www.namsdl.org/IssuesandEvents/NEW%20Involuntary%20Commitment%20for%20Individuals%20with%20a%20Substance%20Use%20Disorder%20or%20Alcoholism%20August%202016%2009092016.pdf
[13] Article 5 of the *European Convention on Human Rights* (the *Right to liberty and security)* states that:
Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;