West Sussex Safeguarding Adults Board

Safeguarding Adults Review in respect of DJT

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1. Foreword

1.1. The West Sussex Safeguarding Adults Board (SAB, or the Board) has published a Safeguarding Adults Review (SAR, or Review) in relation to DJT.

1.2. The Board and the Independent Reviewer wish to express their sincere condolences to DJT's family and those who knew and worked with him. DJT's family were not able to contribute to the Review with this not being possible for his daughter and sadly, his eldest son having died in August 2019. Therefore, the information about DJT was provided by those who closely worked with him.

1.3. Those who worked closely with DJT described him as a caring man with a good sense of humour. Being Polish, he enjoyed traditional home cooked Polish meals. He liked the "old traditions of family life" whereby he worked, brought in the income, and enjoyed a meal ready for him when he got home. DJT preferred direct communication and felt English people considered "tea" to be the answer to everything and were too polite.

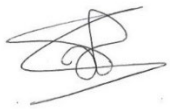
1.4. DJT was a painter and decorator and while working, a sharp object penetrated his eye for which he required surgery. This injury resulted in glaucoma and sight loss. The following loss of his job and sight, alongside the loss of his family, contributed to a significant decline in his overall wellbeing and led to him drinking excessive quantities of alcohol. DJT's needs for care and support increased as his sight deteriorated and DJT self-neglected in the areas of personal hygiene, nutrition, and finances.

1.5. DJT's health continued to decline and on the 25th of April 2021 DJT required hospital admission where he sadly, passed there on 19th May 2021. His cause of death was multiple organ failure, of which decompensated alcohol related liver disease due to alcohol use was the underlying cause.

1.6. Following DJT's death a SAR referral was made to our Board in August 2021. The SAR subgroup acknowledged the areas of improvement, including multi-agency risk assessment, assessment of mental capacity, consideration of previous history/trauma, person-centred approaches, responses to quality concerns, and how effectively DJT's physical health care needs were met. It was agreed that the criteria for a SAR was met and Independent Reviewer, Patrick Hopkinson, was appointed to lead this Review.

1.7. The purpose of a SAR is to identify how lessons can be learned, and services improved for those who use them, and for their families and carers. This Review looked at the circumstances prior to DJT's death and the actions of agencies. Recommendations made will enable lessons to be learned and contribute to service development and improvement. Although agencies have not waited for the outcome of this SAR to consider their own learning, we will ensure that they are fully engaged in taking forward, together, the Review recommendations.

1.8. The Board will monitor progress on the implementation of recommendations to reduce risks and ensure the development of systems and procedures to improve practice. The Board will also ensure that learning from this Review is widely shared and that the outcomes of the learning will lead to improved services in West Sussex.



Annie Callanan, Independent Chair

2. Introduction

2.1. The Care Act 2014, Section 44, requires that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when certain criteria are met. These are:

- When an adult has died because of abuse or neglect, or has not died but experienced serious abuse or neglect, whether known or suspected, and;
- There is a concern that partner agencies could have worked more effectively to protect the adult.

2.2. Safeguarding Adults Reviews are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership, and accountability.

2.3. The aims of the Safeguarding Adults Review are to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy and support family and friends.

2.4. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations. It is not the purpose of the review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

2.5. The review process to meet these aims and objectives has followed a clear path. The Independent Reviewer has chaired an initial panel meeting to agree the review terms of reference; conducted research by critically analysing Individual Management Reports (IMRs), chronologies and relevant records held by involved agencies and by interviewing representatives of agencies; culminating in a planned Safeguarding Adults Review Outcome panel meeting and presentation to the West Sussex Safeguarding Adults Board.

3. Overview of the case and circumstances leading to the review

3.1. A referral was made by West Sussex County Council on 5th August 2021. The referral for DJT was first considered on 5th August 2021, and at this time the SAR Subgroup considered an Assurance Action Plan, or a learning event, may be more helpful than a SAR.

3.2. On 4th November 2021 the decision to not proceed with a SAR was reconsidered. It was agreed to proceed with a SAR.

3.3. DJT was a painter and decorator and while working a sharp object penetrated his eye for which he required surgery. DJT then developed glaucoma and lost some of his sight. DJT suffered further trauma when his eldest son died aged 21 years old and his marriage ended. DJT drank alcohol and was often intoxicated. DJT's needs for care and support increased as his sight deteriorated and DJT self-neglected in the areas of personal hygiene, nutrition and financial responsibility. This was often through "unwise" choices influenced by his alcohol dependency, which was exacerbated by his mental health instability and sight loss. Over time DJT was supported by four different care agencies, but there was some evidence of possible neglect by two of the care agencies in not providing all the support they were commissioned to deliver. This included support with personal care, helping DJT to manage his home environment, medication management, and support with correspondence, bills and assistive technology. There was evidence of possible organisational abuse by one care agency in that care visits were too close together.

3.4. Summaries of Involvement/IMRs were not requested from agencies because information had been collated by West Sussex County Council (WSCC), Adur District Council and Worthing Borough Council.

3.5. The scoping period for this Review is from August 2019 to 19th May 2021.

4. Key themes identified for this review

4.1. How effective was multi-agency needs/risk assessment and communication? Including:

- the need for holistic assessment and risk assessment
- multi-agency planning
- identifying a lead for coordination of care
- fire risk

4.2. How effectively was mental capacity, previous history/trauma, and the person's voice addressed? Including:

- consideration of trauma that DJT had experienced and the impact of this on his psychological wellbeing

- the focus of mental health assessment being around risk of suicide, without consideration of the significant trauma DJT had experienced
- consideration of mental capacity regarding care needs/safeguarding
- gaps in putting the person at the centre of activity

4.3. How person-centred were the approaches used?

4.4. How effective were responses to quality concerns and, in reducing the risk of abuse and neglect? Including:

- actions taken/not taken following two quality concerns being raised
- extra care provider declining to provide all support as commissioned
- were safeguarding processes used appropriately?

4.5. How effective was DJT's physical health care including management of glaucoma? Including:

- prescriptions
- monitoring
- interventions

4.6. What was the impact of the Covid-19 restrictions on access to services and on the responsiveness of services?

4.7. How compliant were agencies in meeting statutory and procedural requirements? Including:

- safeguarding adults procedure
- escalation protocol
- Mental Health Act assessments

5. Pen picture of DJT

5.1. DJT was the proud father of two sons and a daughter. DJT enjoyed cycling, football, swimming, music and cars. Practitioners described DJT as a caring man with a good sense of humour. DJT was Polish and enjoyed traditional home cooked Polish meals. He said he was used to the "old traditions of family life" whereby he worked, brought in the income and enjoyed a meal ready for him when he got home.

5.2. DJT was a painter and decorator and enjoyed his job. However, while working a sharp object penetrated his eye for which he required surgery. DJT then developed glaucoma and lost some of his sight. DJT's eldest son died in August 2019 aged 21 years old when he was at university. DJT blamed himself, believing that he had pushed his son to get a good education. DJT's marriage subsequently ended.

5.3. DJT felt English people considered "tea" to be the answer to everything and were too polite. DJT preferred direct communication. For example, if his hygiene was noticeably poor, he would prefer someone to say "you need to take a shower" instead of asking if he would like help. Since good food was important to DJT and as he disliked microwave/convenience foods, a slow cooker was purchased as part of his support planning so that stews and casseroles could be made. It appears however that DJT was not supported to make use of the slow cooker.

5.4. DJT was desperate to remain independent and attempts were made to find a Polish/English speaking Personal Assistant (PA) to support him with cooking, maintaining his environment, accessing the community, and dealing with correspondence. DJT had periods of wanting to make changes and being very positive, but this would be followed by periods of feeling helpless which led to him drinking excessive quantities of alcohol to block out the things he was unable to do, due to impaired sight, hallucinations, insomnia and the loss of his family. DJT reported that drinking alcohol was the only way for him to minimise the hallucinations he suffered due to Charles Bonnet Syndrome.

6. Engagement of services with DJT's family

6.1. DJT was separated from his wife, who spoke little English. According to WSCC, whilst DJT's wife cared what happened to DJT, she did not want to be involved with him or with helping agencies to engage with him.

6.2. DJT's son did not see his father as he was kept away by DJT's alcohol dependency. DJT's adult daughter was in contact with DJT, but this was infrequent because she found it difficult to see her father in the condition he was in. DJT was visited by his daughter shortly after he had received a retrospective Personal Independence Payment (PIP). DJT gave all this back payment to his children as he felt he owed it to them for having not been there for them when they needed him. However, this left DJT with limited money. DJT's daughter was due to visit DJT again when he moved into extra care housing to help with unpacking and contacting utility agencies. It is unclear, however, whether she did make this visit. There was more contact with DJT's family in the weeks leading to DJT's death. WSCC contacted DJT's family and, with the agreement of DJT's wife, asked DJT's son's school to offer his son pastoral support.

7. Summarised chronology

7.1. In August 2019 DJT's son, a university student, died.

7.2. On 5th October 2019 DJT attended the accident and emergency department because of alcohol withdrawal symptoms and expressed suicidal ideation.

7.3. On 13th November 2019 DJT suffered an accident at work where an object went into his eye causing a corneal abrasion.

7.4. On 14th February 2020 DJT's GP visited DJT at home because his blood test results were consistent with excessive alcohol use. The GP found DJT's home to be in a "squalid" state. Because DJT had lost some sight in both eyes, the GP referred him to ophthalmology and made a referral to WSCC for help with cleaning his flat.

7.5. On 25th February 2020 DJT was diagnosed with chronic closed-angle glaucoma, thought to have been caused by his eye injury.

7.6. On 25th February 2020 DJT was referred to Going Local which is part of Adur and Worthing Councils (AWC) and is a network of social prescribers who work closely with GPs to connect people to a range of community resources to tackle non-medical issues, such as support around benefits and social isolation. DJT already had support from Sight Savers and Rehabilitation Officers from the Visually Impaired team (ROVI).

7.7. On 6th March 2020 DJT had his first meeting with AWC and was supported to start a PIP claim, chase the benefits office over the status of his Universal Credit claim, and to complete an online housing form. DJT had been served with an eviction notice and he was unable to afford his prescription eye drops (for glaucoma). He was not entitled to free prescriptions because he was not in receipt of Universal Credit.

7.8. During March 2020 Sussex Police were called several times when DJT was found wandering on train tracks.

7.9. On 6th April 2020 Sussex Police raised a safeguarding concern when DJT was found on the street. West Sussex County Council (WSCC) dealt with the matter under the Sussex Multi Agency Procedures for people who Self-Neglect. In accordance, therefore, with their policy and practice, it was handled as a care management issue rather than under S42 of the Care Act.

7.10. On 9th April 2020 DJT attended St Richard's Hospital for an eye appointment as his eye condition had deteriorated. According to the GP notes he was kept in for an operation for removal of the lens of the right eye and insertion of prosthetic replacement. According to WSCC, however, DJT did not have a prosthetic replacement.

7.11. On 16th April 2020 4sight Vision Support sent an email to WSCC and the hospital social work team raising concerns about DJT being discharged from hospital without a care package. However, according to hospital records DJT had not been discharged at this point.

7.12. On 22nd April 2020 DJT was discharged from hospital back to his home with a care package of three care visits a day to support him with meals, personal care and managing his flat.

7.13. On 30th April 2020 DJT complained to AWC that he had no food or money, that his carers were unable to shop for him and would not drop off his PIP form for him, and that he needed to pay his telephone bill or he would get cut off.

7.14. On 24th June 2020 WSCC contacted the current care provider (Care Agency 1) because some of the carers had been declining to support DJT with correspondence and technology.

7.15. On 13th July 2020 DJT's carers contacted WSCC's out of hours service and reported that DJT was intoxicated and were concerned because he smoked. It was agreed that the carers should do an extra call later that night and for them to report back to the out of hours service. DJT was in bed asleep when the carers visited later.

7.16. On 17th July 2020 Care Agency 1 contacted WSCC concerned that DJT was drinking more alcohol than usual and neglecting himself by declining support with his personal care and was not eating.

7.17. On 20th July 2020 WSCC initiated their quality issues pathway (submitted a quality referral) on the basis of poor practice by Care Agency 1, specifically that they were not supporting DJT as set out in the care plan, that his clothes were soiled with urine and faecal matter, which was attracting flies, that he was not being supported with medication, his nutritional needs or with managing his home environment and correspondence.

7.18. On 25th July 2020 DJT attended Worthing A&E with thoughts of suicide. The hospital made a referral to Sussex Partnership NHS Foundation Trust's two dedicated mental health crisis assessment facilities (known as The Haven), but both were full.

7.19. On 11th August 2020 a second quality referral was initiated by WSCC. This was on the basis that there was no improvement in the care being provided by Care Agency 1.

7.20. On 21st August 2020 DJT's care was transferred to a new provider (Care Agency 2). Care Agency 2 did not engage well with DJT and the plan was to keep the provider in place until a personal assistant (PA) could be found for DJT.

7.21. On 2nd September 2020 AWC found that DJT had a black eye with dried blood over it and had nearly set his curtains on fire, and on 21st September 2020 spoke to WSCC about the risk of fire. WSCC would provide a sand bucket.

7.22. On 30th October 2020 a multi-disciplinary team meeting was held to discuss DJT's planned move to Extra Care accommodation. This was to provide a higher level of care and more social stimulation and to locate DJT further away from railway lines. In his current location DJT was very close to railway lines and there was a risk that he might go out by himself, become disorientated and accidently walk onto the track. WSCC were to consider increasing DJT's care package to cover health and wellbeing needs and to try to prevent DJT being in contact with other drinkers in the building.

7.23. On 14th December 2020 DJT moved to his new extra care accommodation. Responsibility for DJT's care was transferred to Care Agency 3. DJT was to receive six weeks of intensive wellbeing support directly following the move: WSCC Adult Social Care and the Rehabilitation Officer Visual Impairment (ROVI) were to provide a week of support for DJT to help him with the move; ROVI would continue to support DJT with orientation for two weeks following the move; carers were to help with correspondence until a PA could be found and AWC were to help with debt issues. However, AWC were unable to assist as their worker allocated to DJT had to self-isolate in line with government measures to reduce the spread of coronavirus.

7.24. On 16th December 2020 DJT had been drinking again and ROVI withdrew its support, and wellbeing support provided by AWC was closed. Support from the AWC social prescribing team continued.

7.25. On 4th January 2021 DJT had no food in his fridge because the carers were not allowed to go with him to get cash out in order to pay for the shopping.

7.26. From 24th January 2021 two extra hours per week of care commenced to help DJT access community activities and engagement.

7.27. On 4th February 2021 Care Agency 3 refused to provide support to DJT with his bills and correspondence, saying they never did this because they needed clear boundaries between housing and care.

7.28. DJT had been found with a belt around his neck. DJT explained that he did this while he moved from room to room. In case DJT was having a mental health crisis, on 10th February 2021, an extra care housing officer made a referral for a Mental Health Act assessment as a precaution. An assessment was rejected by the AMPH service.

7.29. On 10th February 2021 WSCC received a safeguarding concern from the South East Coast Ambulance Service NHS Foundation Trust (SECAmb) about DJT's self-neglect. It was entered to WSCC's system and then closed down as it was being supported under 2.8 of the Sussex Multi-agency Procedures to support adults who self-neglect policy (Self-Neglect Procedures).

7.30. On 10th February 2021 a risk enablement plan was drawn up in consultation with DJT with actions for Care Agency 3 to support DJT's care needs, for CGL (alcohol services) to look into residential rehabilitation, for AWC to support with debt management, benefits and residency applications, for ROVI to support with communications software and for WSCC to arrange a multi-agency professionals meeting under the Self-Neglect procedures.

7.31. On 21st February 2021 West Sussex Fire and Rescue Service did a fire safety visit and sprayed fire retardant around DJT's flat and issued a smoking blanket.

7.32. On 5th April 2021 West Sussex Fire and Rescue Service were called to a fire alarm in the night. DJT was intoxicated and had fallen asleep with a lit cigarette, causing the sofa and a blanket to burn. The following day Care Agency 3 raised a safeguarding concern with WSCC regarding the incident citing trauma in DJT's life.

7.33. On 6th April 2021 WSCC initiated a safeguarding enquiry following concerns that DJT was self-neglecting.

7.34. On 7th April 2021 the West Sussex Fire and Rescue Service visited DJT again and contacted the accommodation provider because DJT's care needs had increased since their previous visit in February 2021.

7.35. On 7th April 2021 AWC, WSCC and DJT's GP also visited DJT. They found unopened post and bills and there were significant concerns about DJT's health, however the GP did not feel that DJT's oxygen levels were such that he should be admitted to hospital. WSCC increased care visit support during the day and, from 8th until 14th April, put in night support which was provided by Care Agency 4.

7.36. On 25th April 2021 DJT was admitted to hospital and was placed in the intensive care unit and on 30th April DJT was moved to a ward.

7.37. On 4th May 2021 WSCC received an application for deprivation of liberty safeguards (DOLS) from the hospital because DJT required a nasal tube for nutrition and mittens to prevent him from removing his canula (for intravenous antibiotics) and catheter, both of which he had been doing. The hospital cited

"encephalopathy" which is damage or disease that affects the brain and leads to an altered mental state.

7.38. On 19th May 2021 DJT passed away in hospital. The immediate cause of death was multiple organ failure, of which decompensated alcohol related liver disease was the underlying cause.

7.39. Sight loss - chronology, description, and treatment. This is shown in more detail at Appendix A.

8. Key findings

8.1. The policies of two of the care agencies impeded the provision of an individualised and appropriate programme to meet DJT's complex care needs. Care and support failings around help for DJT with medication and his home environment put DJT's health, including his limited remaining vision, at risk. The refusal of care agencies to provide support with correspondence, bills and technology meant that specialist agencies had difficulties engaging with DJT and opportunities for better outcomes for DJT were reduced. Inconsistent support with correspondence, financial matters and paying bills put DJT's security and wellbeing at risk (see recommendations 1, 2, 3 and 8).

8.2. Whilst WSCC sought to manage the risks as they emerged, a more robust response may have been beneficial, for example, in taking a more active and authoritative approach with care agencies to ensure they reviewed and changed their policies. The use of section 42 enquiries may have been helpful in this (see recommendations 1 and 3).

8.3. Prior to the involvement of AWC, DJT struggled and failed in his attempts to apply for Universal Credit through the Benefits Office. The Benefits Office's requirements and DJT's disability made it difficult for DJT to apply for benefits. It may be beneficial to explore with the Benefits Office how they may work in partnership with agencies such as adult social care to improve the client experience for those with disabilities (see recommendation 4).

8.4. There were several agencies involved, or which attempted to be involved, in DJT's care and support. However, no one individual was appointed to coordinate DJT's complex needs and agencies' response to them. This resulted in multi-agency working that was not consistently joined up and which hampered efforts by agencies to engage with DJT (see recommendation 5).

8.5. There were moments where DJT was motivated to change, but opportunities were not always taken to capitalise on them, and on one occasion, despite efforts made by two of the agencies to formulate and put in motion a specific intervention, another service, on which the intervention relied, was not engaged in the plan (see recommendations 5 and 6).

8.6. More consideration should have been given to assessing DJT's mental capacity to make decisions, particularly in light of his self-neglect, his substance use and experience of trauma (see recommendation 7).

8.7. It is possible that more could have been done to attempt to secure free prescriptions for DJT at an earlier stage, so that he could access eye drops prescribed to help prevent further sight loss.

8.8. Whilst professionals were aware of DJT's trauma in respect of the death of his son, breakup of his marriage and his sight loss, and referrals to specialist services were made, apart from anti-depressants, little support, such as talking therapies or bereavement counselling were offered to support DJT with his mental health. Trauma-informed approaches do not appear to have been employed in working with DJT and a (suicide) safety plan as recommended by the Royal College of Psychiatrists was not drawn up (see recommendations 9 and 10).

8.9. A referral for a fire risk assessment should have been triggered at an earlier stage and some fire protection and minimisation measures were not implemented (see recommendations 11 and 12).

8.10. WSCC's systems for logging safeguarding enquiries could be improved (see recommendation 2).

8.11. The Covid-19 pandemic and government measures to restrict the spread of coronavirus during 2020/21, linked with DJT's disability, had a negative impact on some agency's abilities to engage with DJT.

9. Analysis of findings

9.1. Meeting DJT's care and support needs

9.1.1. DJT's care and support needs were not fully and consistently met despite the efforts of WSCC, AWC and other agencies. There was a catalogue of events and practice that contributed to this, including the policies of some agencies related to data protection and dealing with money which resulted in them refusing to support DJT with correspondence, paying bills, answering his telephone and responding to calls and messages from specialist agencies. This put DJT's safety and security at risk and hampered, and on occasion, prevented, his engagement with specialist agencies to whom he was referred in order to help him with aspects of his life and health including recovery from alcohol addiction**.** Practitioners also referenced other factors which complicated the provision of support to DJT. These included DJT's changing needs and alcohol consumption. Practitioners found it difficult to engage with DJT, who needed to be in receipt of his state benefits before other interventions could be implemented, for example, to enable him to pay for a company to support him specifically with his finances.

9.2. Commissioning

9.2.1. Three care agencies were commissioned to provide support to DJT with his personal care, with managing his home environment, medication, correspondence, finances, paying bills and with shopping and meeting his nutritional needs. Attempts were made to find a personal assistant (PA) for DJT, and when Care Agency 3 started providing care in December 2020 it was noted that they should continue to help DJT with correspondence until a PA could be found.

9.3. Practice of agencies

9.3.1. Care agencies 1 and 3 did not provide all the support they were commissioned to deliver and as a result did not meet DJT's complex care needs.

9.3.2. It was noted in July 2020 that Care Agency 1 was not supporting DJT as set out in the care plan; that his clothes were soiled with urine and faecal matter, that there was soiled washing on the floor, and soiled bathroom facilities all of which were attracting flies; that DJT was not being supported with his nutritional needs, nor with managing his home environment and correspondence. Carers were not administering his eye drops, nor checking that DJT had done it himself, despite the daily use of prescription eye drops being essential to help prevent further sight loss. DJT's other medication was either out of date or had run out without any renewed prescription. Care visits were too close together, allowing insufficient time between doses of medication.

9.3.3. In August 2020 it was noted that Care Agency 1's care visits were still too close together, which resulted in DJT declining medication as he feared that the carers were overdosing him. Food was being wasted as new food was being bought before existing food was eaten. There were fruit and vegetables in DJT's flat which were dated from the previous month and flies were everywhere. Bills were not being paid. DJT asked the carers to support him to buy some new clothes as he had lost a significant amount of weight. However, they told him to go to a charity shop and buy them for himself. The carers also told DJT that they had no time to provide him with the support detailed in his care plan.

9.3.4. Care Agency 3 began supporting DJT when he moved into Extra Care accommodation in December 2020. Although occasionally DJT arranged a taxi to a local petrol station so he could buy alcohol, he generally required support to buy provisions. In January 2021 it was found that the carers had not done any shopping for DJT and as a result he had no food in his fridge. Apparently, carers were not allowed by Care Agency 3 to accompany and support DJT to attend a cash point or bank to get cash out. Yet DJT could not get cash out on his own. Although carers had previously been using DJT's bank card to pay for shopping, it appears that at this point a decision had been made that the carers were to use cash which was to be given to them by DJT. Because DJT could not access cash, the carers had not done his shopping. Care Agency 3 did not allow carers to shop for DJT at a larger store where food was cheaper. This was despite DJT being in debt and the need for him to be able to keep his living costs down so as not to worsen his financial position further.

9.3.5. Both Care Agency 1 and Care Agency 3 refused to support DJT with correspondence and assistive technology.

9.3.6. On 4th February 2021 Care Agency 3 told AWC that they had never provided support with correspondence and bills since these were housing issues and they required clear boundaries between housing and care.

9.3.7. Following a fire incident on 8th April 2021, an agreement was reached with DJT that his cigarettes would be removed from him if he became intoxicated. According to Care Agency 3 they adhered to this, however Care Agency 3 refused to support DJT to spray furniture with fire retardant. Also, on 8th April a representative from Extra Care visited DJT. They found that DJT had lost significant weight as he could not feed himself, he was disoriented and confused and his bathroom and clothing were covered in faeces. DJT was unable to toilet himself independently. It is not clear whether Care Agency 3 was not meeting its obligations with WSCC, at least in part (for refusing to remove DJT's cigarettes and for not cleaning DJT's bathroom and attending to his personal care), or whether the situation was wholly attributable to DJT's support needs increasing to an extent that he required extra support.

9.4. Response to care agencies' failures to meet care and support needs

9.4.1. Care Agency 1 - quality concerns of July and August 2020.

9.4.2. On 20th July 2020 WSCC initiated their quality issues pathway due to poor practice by Care Agency 1. WSCC discussed their concerns with Care Agency 1. WSCC explained that the care visit times of 12 midday for breakfast followed by lunch at 1:30pm were inappropriate. They explained the need to engage with DJT in conversation and about matters to do with him and his accommodation. For example, the carers reported that they could not find DJT's mail to be able to support him with it, nor could they find a mop and they could not get the washing machine door open but had not asked DJT. WSCC explained the risks of leaving an excessively wet floor for someone who was blind. WSCC also advised that the carers should accept support from ROVI and social work staff. WSCC asked the carers to take an empathetic approach to DJT's circumstances, to guide him to his food, to explain to him everything they were doing and where they had left items that DJT would need, such as cup, mobile telephone, walking stick. Care Agency 1 said they could not force DJT to accept support. WSCC advised that when DJT was intoxicated and incapacitous, and if he had vomited, was incontinent, and was not safe to be left alone, they should make a best interests decision on his behalf to call an ambulance. No deadline for improvement was agreed with Care Agency 1, but the expectation was for immediate change because of the level of concern raised. It appears that WSCC did not communicate this expectation to Care Agency 1.

9.4.3. There were examples of neglect (for instance, DJT was left in an unhygienic environment and his nutritional and medication needs were not being met) and potential organisational abuse (for instance, care visits were too close together) by Care Agency 1. However, WSCC dealt with the matter under its quality pathway procedures rather than as a safeguarding enquiry under Section 42 of the Care Act 2014. WSCC took a case management approach to a quality concern. WSCC considers that this was the correct approach according to its current policy and practice.

9.4.4. It is likely, however, that the criteria for a safeguarding enquiry under Section 42 of the Care Act 2014 had been met and therefore WSCC was required to carry out an adult safeguarding enquiry. Section 42 of the Care

Act 2014 requires a local authority to make statutory safeguarding enquiries where it has reasonable cause to suspect that an individual with care and support needs is experiencing, or is at risk of, abuse or neglect and as a result of these care and support needs is unable to protect themselves against the abuse and neglect.

9.4.5. If the Pan Sussex Safeguarding Adults Threshold document had been followed, a referral would have been made to the Safeguarding Hub to consider if the criteria for Section 42 Care Act 2014 enquiry had been met. If a safeguarding enquiry had been made, then, for example, the six principles of safeguarding should have been applied. These are empowerment, prevention, proportionality, protection, partnership and accountability. It is clear that WSCC sought to prevent neglect from happening again by speaking to the care agency, but there is insufficient detail in the case notes provided to the SAR author to determine if and how all six principles were applied, and whether WSCC developed a personalised safeguarding plan with DJT.

9.4.6. Had WSCC dealt with the matter as a safeguarding enquiry, the care agency may have acted with greater urgency and commitment. It was required, for example, to notify the Care Quality Commission, the sector regulator, that a safeguarding concern had been raised or that any other incidents had occurred. By 11th August 2020 no improvement had been made.

9.4.7. It may have been helpful to have involved the WSCC contracts (commissioning) team to help manage and enforce the terms of the contract. WSCC sent details of the quality concern which was raised on 22nd July 2020 to the WSCC contracts team on 27th July, but there does not appear to have been any response by the contracts team, nor any follow up. It may also have been helpful to have explored why the care agency was not meeting the terms of the contract and whether there were any joint solutions that would ensure the agency could meet its obligations. It is of particular note that WSCC responded to the quality concerns by showing the carers how to take a person-centred approach to working with DJT. This is a fundamental aspect of providing support, and should be central to care workers' training. Whilst it was good practice on the part of WSCC to seek to address this, the care agency should not have put them in the position of needing to do so.

9.4.8. It is unclear if WSCC was aware of DJT's alcohol use when it commissioned Care Agency 1 to support him. During the process of this review, Care Agency 1 identified that it had not been notified of DJT's alcohol use. It would have provided additional training to its staff and would have used other interventions in response to the complexity of DJT's needs, if it had been notified of this when it first started to provide services to him.

9.4.9. As a result of Care Agency 1's inability to improve in its provision of care and support to DJT, on 11th August 2020 a second quality referral was initiated by WSCC. Again, this was not considered to require a safeguarding enquiry even though it was highly likely that the criteria for a S42 enquiry had been met. WSCC sought to resolve the situation by appointing a new care agency.

9.4.10. The new provider was to be kept in place until a PA could be found. However, there were difficulties finding an appropriate PA and it was suggested that DJT needed to stop drinking in order to have a PA. By the time DJT died in May 2021 he still had not been provided with a PA. This was due to medical reasons and the coronavirus pandemic. Usually PAs are provided under direct payments arrangements. It is not clear how DJT would have managed direct payments, had a PA "worked" for him.

9.4.11. **Care Agency 3 and food shopping**

9.4.12. It is unclear what statutory agencies did in response to Care Agency 3's refusal to accompany and support DJT to withdraw money, and related issues to do with food shopping. This resulted in DJT having no food in his fridge. According to WSCC, care staff regularly bought DJT alcohol using his bank card, so WSCC questioned why the carers could not use his bank card to buy food and pay bills. According to WSCC when they questioned the carers "there were times when the carers said they could not take DJT to the shops due to the risks, bank cards were contactless at the time for up to £30 and there was always vodka in the flat. One of the carers was putting snack foods in the fridge and also bringing in meals cooked from home." The matter was not resolved and it would appear that WSCC could have considered Care Agency 3's refusal to buy food and to support DJT to withdraw money as potential neglect.

9.4.13. **Care Agencies 1 and 3 refusal to support DJT with correspondence and technology**

9.4.14. Both care agencies claimed that to support DJT with correspondence and technology would breach data protection regulations. In response WSCC told the care agencies that they acted as DJT's eyes to help him navigate through caller-options on telephone calls and to set up direct debits. There did not appear to be any questioning or checking of whether the care agencies' interpretation of data protection legislation was correct.

9.4.15. The care agencies refusal to support in these areas potentially had a major impact on specialist's agencies ability to engage with DJT.

9.4.16. There is evidence that some specialist agencies to whom DJT had been referred did not engage with DJT at all, or closed their support early due to his non-response, but his lack of response was at times due to factors outside of his control. For example, on 10th April 2020 One Stop closed support to DJT because he was not responding to voicemails and for the same reason MIND stopped support on 15th April 2020. DJT had not responded to voicemails because in the former case he was in hospital and in the latter case because his partial sight made it difficult for him to use his mobile telephone. On 17th July 2020 the Citizens Advice Bureau closed DJT's case because he did not answer his telephone at the agreed time. On 23rd July 2020 AWC closed volunteer support for DJT because they were unable to contact DJT.

9.4.17. In October 2020 CGL were considering closing support to DJT due to lack of engagement and then on 26th November 2020 the GP notes refer to DJT

being unable to understand text messages from CGL because he could not see well enough to read them clearly.

9.4.18. Given the impact of lack of support in these areas on DJT, on his ability to engage with services and subsequently on his health, and on his wellbeing and security, and having had similar problems with Care Agency 1 it may have been helpful to have taken particular steps to ensure the same situation could not have happened again. For example, WSCC could have explored whether the agencies' interpretation of the data protection regulations was correct. The Data Protection Act 2018 protects the human rights of people using services by ensuring information held about them is:

- held only with consent
- held securely
- shared only on a "need to know" basis
- accessible to them

9.4.19. Supporting DJT with bills and technology in light of his sight impairment was essential, and therefore carers had a 'need to know'. Consent could have been sought from DJT for his carers to have access to his information for specific purposes. It would have been unlawful for carers to have shared the personal information they acquired from supporting DJT, unless there was a 'need to know', and indeed it would have been a criminal act to have used or passed on information to perpetrate fraud. However, this should be covered by care agencies' contractual arrangements, policies and training of workers and employees.

9.4.20. For the benefit of other adults with care and support needs who have no or partial sight it would be helpful to obtain a definitive opinion on data protection legislation and how that interacts with supporting adults with bills, correspondence, and technology. This will enable WSCC to be proactive and authoritative in ensuring that care agencies are able to provide adults with the support that they need, and that they have the correct policies in place to back this up.

9.4.21. **Care Agency 3 - refusal of support with correspondence and bills**

9.4.22. In February 2021 Care Agency 3 told AWC that they had never provided support around correspondence and bills, which were housing issues, because they required clear boundaries between housing and care.

9.4.23. In response AWC reiterated that it was vital that DJT had support with paperwork because of his loss of sight.

9.4.24. WSCC questioned Care Agency 3's position with Extra Care Housing, and with a more senior manager of Care Agency 3, because the agency had accepted the support plan which outlined all DJT's needs due to his sight impairment. Despite DJT's particular circumstances and needs, Care Agency 3 did not change or make an exception to their policy. WSCC did not involve their contracts and commissioning team to seek to enforce the agreement.

9.4.25. Enquiries were made as to whether an alternative provider could go into the Extra Care accommodation to ensure DJT was supported in all areas recorded in the support plan, however, according to WSCC "this was not allowed". It is not clear from WSCC what the source and nature of this barrier was. It is possible that contractual agreements between the accommodation provider and Care agency 3 under the Extra Care arrangement prevented this.

9.4.26. This left a gap in DJT's support. It was WSCC's understanding that this gap was to be filled by AWC who would sort out DJT's benefits and correspondence. However, it appears that AWC did not have the same understanding because two months later, on 7th April 2021, when AWC visited DJT, they found many letters that had been opened, but not actioned, including some threatening enforcement in relation to overdue debts and unpaid bills. There was also a letter informing DJT that there was an outstanding debt for contribution to his care costs.

9.4.27. **Care Agency 3 - April 2021 - not cleaning DJT's bathroom and attending to his personal care**

9.4.28. In April 2021 a written agreement with DJT was put in place, in which if he was intoxicated and unable to look after himself, bests interests decisions could be made on his behalf, such as providing personal care, and removing his cigarettes and alcohol. According to Care Agency 3 they did remove his cigarettes in these circumstances. It is not clear whether WSCC spoke to Care Agency 3 with concerns about keeping his home hygienic. WSCC's approach focussed on the belief that DJT's support needs had recently increased. WSCC agreed to increase the number of hours of day support for DJT and, for one week and subject to review, to provide night support. DJT would not allow the worker supporting him overnight to stay in his flat, and therefore, this worker sat in the communal lounge. Extra Care Housing suggested alternative accommodation for DJT with a higher level of care and more opportunity for social stimulation, and took DJT to visit this. DJT was not happy to move there because he did not know the layout. It is not clear whether this was explored further with DJT, or consideration was given to how DJT may be supported to cope with yet another move of home, or how further support from ROVI could be offered so that DJT could become familiar with another set of new surroundings.

9.4.29. In summary, the policies and practices of two of the care agencies impeded the provision of an individualised and appropriate programme to meet DJT's complex care needs and hampered the efforts of other agencies in work with DJT.

9.4.30. There may have been other factors that contributed to the struggle to engage with DJT. For example, Care Agency 1 said that they found it hard to support DJT because he was often intoxicated. Consequently, even if the barriers to effective communication between agencies and DJT had been fully overcome it is impossible to have guaranteed that better outcomes for DJT would have been achieved. However, the opportunities for better outcomes were put at risk by care agencies' refusal to support DJT with technology. Inconsistent support around correspondence, financial matters and paying bills put DJT's security and wellbeing at risk.

9.4.31. Whilst WSCC sought to manage the risks as they emerged, a more robust response may have, for example, recognised that DJT was being neglected. As a result, this could have led to referral to the safeguarding hub to consider whether the criteria for a Section 42 enquiry had been met. This could have led to a more active and authoritative approach with care agencies to ensure that they reviewed and changed their policies.

9.5. Obligations under Equality Act 2010 and engagement with DJT

9.5.1. It appears there were instances where agencies (including agencies beyond the partner agencies of the West Sussex Safeguarding Adults Board) may not have done enough to support DJT in light of his partial sight, which most likely would have been classed as a disability under the Equality Act 2010. For example, once DJT became unable to work, the only income DJT was receiving was Statutory Sick Pay. He tried to claim Universal Credit, but this was very difficult as he had no transport or money to get to the Benefits Office in Worthing. He had to attend this office in order to provide the required documentation, but he was unable to find the right documents because of his sight impairment. He walked alone, with great difficulty, from his home to the Benefits Office in Worthing twice, a distance of over a mile. However, he did not have the correct documents with him and his claim was not actioned by the Benefits Office. Given that many of the Benefits Office's clients are likely to have some form of disability it should be considered whether more could be done in the form of reasonable adjustments to enable clients to access their service and apply for benefits. There is a need for balance between what support services can do to assist people to apply for benefits and what reasonable adjustments the Benefits Office can make to improve accessibility. It may be beneficial to explore with the Benefits Office how they may work in partnership with agencies such as adult social care to improve the client experience for those with disabilities.

9.5.2. As mentioned in the section "meeting DJT's care and support needs" some specialist agencies struggled to engage with DJT and closed support early due to factors sometimes beyond DJT's control.

9.5.3. ROVI provided considerable support to DJT, including devices, equipment and technology to help with sight impairment, but training DJT in the use of these was difficult because DJT was often intoxicated.

9.6. Coordination of services provided

9.6.1. There was no one agency or practitioner tasked with coordinating the agencies and services involved with DJT. This resulted in multi-agency working that was not consistently joined up.

9.6.2. There was a multitude of agencies to whom DJT had been referred and to varying degrees were involved with, or had made attempts to be involved with, him. Apart from DJT's GP, WSCC, AWC and Sussex Partnership Foundation Trust (SPFT) they included four different care agencies, CGL, Sight Savers, ROVI, MIND, 4sight Vision Support, a community response volunteer, the Worthing Mosque for help with food and the CAB.

9.6.3. Whilst it appears to be good practice to have a variety of different agencies and community resources that can be called upon, it may have been that a multitude of agencies added further complexity to an already complex situation with DJT. On 1st December 2020, for example, it was agreed that the "parish nurse" would be asked to support DJT with social interaction and taking DJT out to food shops. It is not clear if the complexity of DJT's situation was considered and discussed. Adding more people into a complex situation may not have added benefit at that time.

9.6.4. There was no one practitioner appointed to coordinate care, oversee all the agencies involved, make sure they had all the information needed and that they each shared information. There was no one person or agency appointed to eliminate or overcome the barriers to DJT accessing agencies' services and to assist agencies in engaging with him.

9.6.5. In addition, DJT's impaired sight may have made it more difficult for agencies to build up rapport with him, and for DJT to feel comfortable and put trust in practitioners. The more dispersed and varied the number of practitioners, the more confusing and unsettling it was likely to have been for DJT.

9.6.6. Even after DJT had died, services were not coordinated in such a way as to make things easier for DJT's relatives in their bereavement. For example, on 25th May 2021 WSCC asked the representative of AWC to contact DJT's daughter about his finances. The representative was advised by her managers at AWC that this was not within her remit. Subsequently WSCC said that one of its teams could support DJT's daughter and informed AWC accordingly. However, when DJT's daughter contacted the team at WSCC, the team said they could not support her and suggested the Citizens Advice Bureau.

9.6.7. In conclusion, there was a multitude of agencies involved with, or who attempted to be involved with, DJT's care and support. However, no one person was appointed to coordinate DJT's complex needs and agencies' response to them. This resulted in multi-agency working that was not consistently joined up and hampered efforts by agencies to engage with DJT.

9.7. **Recognition of self-neglect**

9.7.1. DJT had been self-neglecting, and this was recognised by services. While on occasion plans were put in place, there is limited evidence that they were followed through.

9.7.2. DJT's alcohol misuse had been going on for some time. For example, DJT attended his GP in August 2012, December 2013 and December 2015 with problem alcohol drinking.

9.7.3. WSCC considered that when DJT received his state benefits he was likely to spend these on alcohol. DJT's alcohol consumption increased from between 500 ml – 1 litre a day to 2 litres per day when he moved into Extra Care housing in December 2020. Practitioners also believed that DJT may have been bored, which led him to drink more.

9.7.4. A risk profile dated 10th February 2021 noted that DJT self-neglected in the areas of personal hygiene, nutrition and financial responsibility. This was often through "unwise" choices influenced by his alcohol dependency which stemmed from his mental health instability and sight loss. During these times DJT was at risk of malnutrition, injury and infection from untreated wounds. It was also noted that DJT did not take his medication nor administer his eye drops when he was intoxicated.

9.7.5. DJT's case was handled under the Sussex Multi-Agency procedures to support people who self-neglect which WSCC consider was the correct approach. A multi-agency professionals meeting under section 2.8. of the self-neglect procedures was held on 2nd March 2021. This was attended by DJT who was able to offer his views with the help of WSCC, together with representatives from Care Agency 3, WSCC adult social care, WSCC Extra Care, ROVI, AWC and CGL. DJT's GP was invited but unable to attend. Worthing Homes were also invited but did not attend.

9.7.6. DJT explained that his sight loss was worrying him because he was unable to see anything and could not do anything for himself. He explained that sometimes his sight improved when he stopped drinking, but when he stopped drinking he experienced hallucinations, which prevented him from moving around. The hallucinations were caused by Charles Bonnet Syndrome. DJT had been diagnosed with Charles Bonnet Syndrome on 5th May 2020. The syndrome is a type of psychophysical visual disturbance in which a person with partial or severe blindness experiences visual hallucinations. DJT said that the only thing that had helped minimise the incidence of hallucinations was alcohol.

9.7.7. Nevertheless, DJT indicated that he was "ready for" in-patient detoxification. An action plan from the meeting held on 2nd March 2021 was drawn up which included the identification of support DJT would need for in-patient detoxification, to explore if funding was available for this, to identify the support he would need on his return home, to arrange a home visit for a blood test for his liver function (CGL needed this to provide a baseline), for carers to support DJT in measuring and mixing his alcohol (in preparation for detoxification) and to check whether Care Agency 3 employed a suitable Polish person who could act as DJT's PA.

9.7.8. DJT's GP surgery was to seek advice on Charles Bonnet Syndrome from a corneal consultant. However, the GP has no record of such a letter being sent, nor of a reply. This was an opportunity lost to have explored whether DJT could be supported in some other way to suppress the hallucinations.

9.7.9. Apart from a blood test, it is not clear what other actions were implemented from the self-neglect meeting before DJT's admission to hospital on 25th April 2021 with chronic liver disease and his continued stay there until his death on 19th May 2021.

9.7.10. DJT spent money on alcohol and practitioners reported that consequently he did not have sufficient money for other essential items such as food. There does not appear to have been a discussion to identify possible interventions to overcome this. It is possible that any such interventions would have been unsuccessful, but nevertheless, should have been tried.

9.7.11. The meeting on 2nd March 2021 held under the self-neglect procedures was attended by DJT and it was good practice to have engaged him in the process. There were a number of plans for action resulting from this meeting. Practitioners, however, have reflected that considerable effort was made by various agencies to engage with DJT over the time period of this Review, but most of the time DJT refused to engage. The meeting on 2nd March may have been an opportunity to have asked DJT how agencies could best engage with him, or failing that, another meeting of practitioners could have been arranged, without DJT, to explore between themselves ideas for improved engagement.

9.8. Making the most of moments of motivation to secure changes

9.8.1. The Sussex Multi-Agency Procedures to Support Adults who Self-Neglect quotes the work of Braye, Orr and Preston-Shoot (SCIE, 2014). Since 2014 these authors have further developed their work and research on self-neglect, and have identified that practice with people who self-neglect is more effective where practitioners engage a number of principles including to "work patiently at the pace of the individual, but knowing when to make the most of moments of motivation to secure changes"[1].

9.8.2. There were moments where DJT was motivated to change, but opportunities were not always taken to capitalise on them, and on one occasion, despite efforts made by two of the agencies to formulate and put in motion a specific intervention, another service, on which the intervention relied, was not engaged in the plan and so it was not followed through. On 24th July 2020 DJT's GP and WSCC visited DJT at home. After a long discussion DJT agreed to be admitted to hospital for self-neglect (concerns about nutrition and weight loss), alcohol dependency and depression and suicidal thoughts. Hospital admissions can be an opportunity for interventions. They represent a transition point. Old routines are temporarily broken and the impetus for change can be at its greatest.

9.8.3. Consequently, this was a significant moment of motivation which the GP and WSCC had worked hard to achieve. However, there was no pre-planned, coordinated and agreed approach with the hospital, resulting in DJT being discharged by the hospital the following day on the basis that he did not have an acute need.

9.8.4. Another example of a lost opportunity to capitalise on moments of motivation was on 4th January 2021. There had been some improvement in DJT's mood and outlook because he was not drinking and was sober. DJT was exercising daily which was helping him sleep. DJT enjoyed his new flat and chatting with neighbours and welcomed support to start cooking and managing in the kitchen independently. Good food was important to DJT and as he disliked microwave/convenience foods, a slow cooker had been purchased as part of his support plan so that stews and casseroles could be made. However, DJT was not supported to make use of the slow cooker. In addition, he had no food in his fridge because the carers had not done his

[1] ADASS (2020) 'Learning Support Document: Self-Neglect and Hoarding'

shopping for him. It is not clear what WSCC did to try to rectify the situation for DJT.

9.9. Mental capacity

9.9.1. More consideration should have been given to assessing DJT's mental capacity to make decisions, particularly in light of his self-neglect, his substance use and experience of trauma.

9.9.2. DJT's mental capacity to make any decisions was not assessed. Apart from instances where WSCC advised the care agency about intoxication and incapacity (see section on "meeting DJT's support needs"), it appears DJT was assumed to have capacity. DJT was often intoxicated and, according to WSCC, mental capacity assessments could not be conducted while DJT was in that state.

9.9.3. The Mental Capacity Act (see Appendix B) applies to the decision making of persons with "an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors". DJT was using alcohol which can have a coercive and controlling influence on decision making and particularly on decisions related to substance use, and can be the cause of the impairment in the functioning of mind and brain, which forms one part of the test of mental capacity[2].

9.10. Decisional and Executive Capacity

9.10.1. The extent to which a person who self-neglects can put whatever decisions they make into effect should also be considered. In DJT's case there were concerns about his ability to self-care and to reduce his alcohol intake. Whilst the Mental Capacity Act currently does not explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice and, subject to consultation, will be included in the proposed revised Code of Practice for the Mental Capacity Act.

9.10.2. There is also growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation) which in turn impacts on mental capacity (for example, Rogoz and Burke, 2016; Gowin et al, 2013; Floden et al, 2008). Of relevance is that, compared with control groups, people with frontal lobe damage caused by alcohol use and traumatic experiences:

- Are significantly slower and less accurate at problem solving when it involves planning ahead.

[2] Department of Health, Bogg and Chamberlain (2015) 'Mental Capacity Act 2005 in Practice: Learning Materials for Adult Social Workers and Mental Health Law Online (2019) 'CD v London Borough of Croydon [2019] EWHC 2943 (Fam)'

- Persisted with riskier behaviours for longer and were less responsive to negative outcomes.

- Were no different when identifying what the likely outcome of an event would be.

9.10.3. As a result, people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening.

9.10.4. The proposed revised Code of Practice for the Mental Capacity Act will, subject to consultation, include guidance on assessing mental capacity where there is an impairment in executive functioning and a mismatch between what a person says and what they do. The proposed revisions include that, "A person who makes a decision which others consider to be unwise should not be presumed to lack capacity. However, a series of unwise decisions may indicate an inability to use or weigh information".

9.10.5. It appears that there was no consideration of whether DJT had frontal lobe damage, and if he did, what that may have meant for his mental capacity to make decisions.

9.10.6. The Sussex Multi-Agency Procedures to support adults who self-neglect (the Self-Neglect Procedures) state," An adult should be presumed to have capacity. However, there may be cases where an adult may lack understanding and insight into the impact of their self-neglecting behaviour on their or others' wellbeing. When an adult's behaviour or circumstances cast doubt as to whether they have capacity to make a decision, then a mental capacity assessment should be carried out." West Sussex Safeguarding Adults Board may see benefit in considering whether the recognition of self-neglect, in itself, should be sufficient to prompt a mental capacity assessment.

9.10.7. A safeguarding concern for DJT in April 2021, after he was found with a belt around his neck, was handled under the Self-Neglect procedures. This did not result in an assessment of DJT's mental capacity. The "Adult Safeguarding Concern" form which was completed as part of these procedures noted that it was not known whether DJT had mental capacity regarding decisions relating to the enquiry. Given this, and previous concerns about self-neglect, it would have been appropriate for a mental capacity assessment to have been carried out at this stage.

9.10.8. In summary, insufficient attention was given to conducting a formal mental capacity assessment. There was also insufficient consideration of whether DJT had frontal lobe damage caused by alcohol abuse and trauma, and which may have affected his mental capacity. This was despite the use of the Self-Neglect procedures in April 2021 and recognition of self-neglect on several occasions prior to this.

9.11. **Medication**

9.11.1. DJT was unable to afford to pay for prescriptions, and initially this meant that DJT did not have access to medication to help prevent further sight loss.

9.11.2. People in receipt of certain government benefits, such as Universal Credit, are entitled to free prescriptions. When AWC became involved with DJT he was not receiving Universal Credit, so he was not entitled to free prescriptions. DJT could not afford to pay for prescriptions, so he did not obtain the eye drops for glaucoma that were essential in prevent further sight loss. AWC helped DJT to apply for Universal Credit on 6th March 2020, which he did not receive until around 22nd April 2020 and on 29th April 2020 AWC contacted DJT's GP to restart prescriptions for his medication.

9.11.3. There was another avenue to entitlement to free prescriptions which does not appear to have been pursued. This was to obtain a medical exemption certificate on the basis that DJT had a continuing physical disability (sight impairment) that prevented him from going out without the help of another person. With this certificate DJT would not have been required to pay for his prescriptions. At the time of writing this Review, medical exemption certificates are provided within 10 working days of application, however, at the time of the Covid-19 pandemic government restrictions in 2020 it may have taken longer. It is therefore difficult to predict whether the medical exemption certificate route would have been quicker than the Universal Credit route for access to free prescriptions, but it may have been beneficial to have pursued both in tandem.

9.11.4. Practitioners also pointed to associated difficulties with obtaining DJT's medication. Firstly, GPs are reducing the number of prescriptions of medication that can be bought over the counter, such as paracetamol and senna. Secondly, that carers can only administer medication which has been prescribed. Practitioners also understood that some of DJT's medications could not be administered while DJT was intoxicated, and this added a further complication to the provision of support to DJT.

9.12. **Mental health needs**

9.12.1. DJT's mental health fluctuated, and whilst actions were considered, such as sectioning under the Mental Health Act, and the provision of talking therapies, little mental health support was delivered to DJT.

9.12.2. It should be noted that DJT experienced bouts of depression prior to his work accident, which impaired his sight, and prior to the death of his son. However, following the death of his son in August 2019, he presented to services more often with depression and suicidal ideation became a feature. From September 2019 through to February 2020 DJT was issued with several fit notes for depression. On 5th October 2019 DJT expressed suicidal thoughts. He was assessed by Sussex Partnership NHS Foundation Trust (SPFT), and he was discharged.

9.12.3. In June 2020 DJT was seen by his GP for depressive disorder and prescribed the anti-depressant sertraline. This also appears to have resulted in a referral for a "time to talk" assessment, a talking therapies service run

by Sussex Community NHS Foundation Trust (SCFT). However, SCFT has confirmed that DJT was not known to their service. On 26th July 2020 staff at Worthing Hospital noted that DJT would benefit from bereavement counselling. Despite these two events, there is no evidence that DJT subsequently was offered and engaged with talking therapies.

9.12.4. Following DJT's attendance at A&E on 6th April 2020 SPFT conducted a mental health assessment by telephone on 16th April 2020 and found he had no immediate mental health needs. On 2nd June 2020 SPFT spoke with DJT on telephone again and, finding his mood had improved, discharged him back to his GP. On 25th July 2020 DJT self-presented to Worthing A&E expressing suicidal thoughts. A mental health assessment was completed with a view for inpatient psychiatric admission. However, there was no room for him at Sussex Partnership NHS Foundation Trust's two acute mental health crisis assessment facilities. DJT was kept in Worthing hospital overnight and reviewed in A&E the following day. The review indicated that in-patient psychiatric admission was no longer needed at that time. It was also noted that DJT would be "hugely vulnerable" on an in-patient ward. It is unclear what was meant by this and its wider implications for adults who may be made "vulnerable" by circumstances. The staff were going to request that Worthing Hospital Alcohol Liaison nurse contact DJT, however, there is no evidence of the nurse attempting contact with DJT. From 8th October 2020 DJT was prescribed mirtazapine (an antidepressant).

9.12.5. On 9th December 2020 DJT was referred by his GP to the community mental health team and attended their clinic on 17th December 2020. It is unclear what the result was. Sussex Partnership NHS Foundation Trust has no record of this referral nor of a visit to their clinic by DJT.

9.12.6. On 10th February 2021 DJT was found with a belt around his neck. He denied any suicidal intention, but an extra care housing officer made a referral for an assessment under the Mental Health Act, to consider whether DJT should be sectioned and detained. The Approved Mental Health Professional (AMHP) team decided not to do an assessment. It is within the powers and discretion of the AMHP to make such a decision. However, the reasons for declining to carry out an assessment in this case do not appear to have been noted. A case note made by WSCC following discussion with the AMHP team said that the plan was for WSCC to refer DJT to an Assessment and Treatment Service so a Mental Health Act assessment could be avoided. This review has not been able to establish why this was considered to be the case. According to SPFT, WSCC was advised to ask DJT's GP to make a referral for "an assessment". It is not clear whether this was an assessment under the Mental Health Act. SPFT stated that the situation did not appear to need an urgent response as DJT denied any current thoughts, plans or intent to harm himself.

9.12.7. Despite reports of suicidal thoughts on 4th October 2019, 12th February 2020, 7th April 2020, 25th July 2020, 14th September 2020 and 8th April 2021, and being found with a belt around his neck on 10th February 2021, no suicide safety plan was drawn up with DJT.

9.12.8. The Royal College of Psychiatrists recommends that a safety plan should be drawn up for a person at risk of suicide and that it should be developed in consultation with the person.

9.12.9. A safety plan is an agreed set of activities, strategies to use and people and organisations to contact for support if someone becomes suicidal, if their suicidal thoughts get worse or if they might self-harm. The components of a safety plan are:

- Reasons for living and/or ideas for getting through tough times
- Ways to make your situation safer
- Things to lift or calm mood
- Distractions
- Sources of support, to include anyone you trust
- The plan should also include specific reference to the removal or mitigation of means of suicide or self-harm

9.12.10. Whilst a form of safety plan called a risk enablement plan was drawn up in consultation with DJT, it was not the same as a (suicide) safety plan as described. It covered various categories of risks, which is good practice. However, it featured very little about the risk of suicide and the only question relating to suicide was what DJT wanted in the event of mental health crisis. DJT's response was an "AMHP referral". Considering the AMHP team's decision very recently not to carry out an assessment, more practical positive steps that DJT could take should he start to think about suicide could have been included.

9.12.11. Trauma informed approaches do not appear to have been employed. WSCC explained that their service was well aware of DJT's trauma due to the death of his son, breakup of his marriage and his sight loss. However, there was no evidence of the use of trauma informed approaches. AWC were unaware initially of DJT's trauma and did not provide evidence of using such approaches. Trauma informed practice is a strengths-based approach, which seeks to understand and respond to the impact of trauma on people's lives and includes paying attention to how to engage people and considering what may have happened to someone, rather than judging what is 'wrong' with them. The approach emphasises physical, psychological and emotional safety and aims to empower individuals to re-establish control over their lives.[3]

9.12.12. The Blue Knot Foundation has produced guidance and resources on trauma informed practice.[4] This guidance has been adapted for the Trauma-Informed Toolkit published by the Scottish Government (2021).

[3] Plymouth.Gov.UK, 'Trauma informed practice'
[4] Blue Knot, 'Guidelines'

9.12.13. In conclusion, whilst professionals were aware of DJT's traumatic experiences, and referrals to specialist services were made, apart from anti-depressants, little support, such as talking therapies seems to have been delivered to support DJT with his mental health. Trauma-informed approaches do not appear to have been employed in working with DJT and a (suicide) safety plan as recommended by the Royal College of Psychiatrists was not drawn up.

9.13. **Fire risk and assessment**

9.13.1. On 2nd September 2020 AWC noted that DJT had a black eye with dried blood over it and that he had nearly set his curtains on fire, yet no referral was made for a fire assessment. On 21st September 2020 AWC raised concerns with WSCC about DJT smoking in his flat and the risk of fire and WSCC said they would arrange for a sand bucket to be provided. There were smoke detectors in DJT's flat.

9.13.2. When DJT moved into the Extra Care accommodation in December 2020, ROVI provided some mobility training for DJT to support him to smoke cigarettes outside. According to ROVI, because of DJT's alcohol use, he was however unable to navigate his way outside, nor to the window, to smoke.

9.13.3. In January 2021 AWC contacted DJT's GP about the risk of fire from DJT smoking.

9.13.4. A Multi-Disciplinary Team meeting under the Self-Neglect procedures was held on 10th February 2021. This involved WSCC, Care Agency 3, AWC, CGL and ROVI. West Sussex Fire and Rescue Service were not involved, and although there is a reference in the Risk Profile completed at the time of fire risk, this was not mentioned in the summary and analysis of risks, nor were any actions around fire risk plans included in the risk enablement plan that was completed for DJT.

9.13.5. A referral to West Sussex Fire and Rescue Service for a fire risk assessment was made on 18th February 2021 by WSCC. The referral could have been made some six months earlier when AWC raised concerns about DJT's smoking, sight impairment and fire risk. The fire assessment conducted on 21st February 2021 noted that DJT used his sofa to sleep on, that he was sleepy during the visit because of medication, that there was evidence of fire (scorch marks), he had "unsafe cooking habits", there were combustible materials near the source of fire, and that DJT's lifestyle was unsafe because it affected his reactions. West Sussex Fire and Rescue Service gave DJT a fire blanket and sprayed fire retardant around DJT's flat.

9.13.6. West Sussex Fire and Rescue Service could have been involved further in developing the risk enablement plan for DJT.

9.13.7. On 5th April 2021 a fire alarm was raised because DJT was intoxicated and had fallen asleep while smoking on the sofa, setting a blanket alight. The fire had been put out by the time the West Sussex Fire and Rescue Service arrived. They made a welfare telephone call to DJT two days later. WSCC commissioned night support from 8th to 14th April because of the fire risk and also because DJT had been found with a belt around his neck. On 25th April 2021 West Sussex Fire and Rescue Service visited DJT in his flat for a

"safe and well visit". As well as the issues noted at the first fire risk assessment, West Sussex Fire and Rescue Service also noted that DJT was unable to evacuate safely in the event of fire and that DJT used naked lights in an unsafe manner. The Fire Service sprayed more fire retardant around the flat and checked DJT's fire blanket.

9.13.8. Care Agency 3 was reticent about taking actions that may have prevented fire. On 8th April 2021 Care Agency 3 told WSCC that they would not support him to spray furniture with fire retardant. They said it was in case their care workers had skin sensitivity, or DJT reacted to the solution, and they did not want to be held liable if their care workers did not apply the spray correctly.

9.13.9. On 21st April 2021 the West Sussex Fire and Rescue Service emailed WSCC urging the use of fire-retardant bedding and textiles at warden assisted properties and warning that the fire of 5th April had come very close to developing into a serious incident. A fire could have affected other tenants. On 26th April 2021 WSCC wrote back requesting West Sussex Fire and Rescue Service conduct another fire safety visit and to consider mobile sprinklers. There were meetings about a sprinkler system, fire retardant bedding and fire-retardant sprays, however, according to WSCC, West Sussex Fire and Rescue Service did not recognise these methods, so these were not taken forward. DJT was supported to obtain a vape to reduce the risk of fire. Agencies advised that they were reactive to any fire risk and that there was much work done in this area.

9.13.10. After DJT's death a learning review action plan was developed by WSCC in consultation with other agencies. This introduced a higher priority response from the Fire Service in the event of a fire for Extra Care Housing properties, ensured that all services were inspected by the Fire Service and that Personal Emergency Evacuation Plans (PEEPS) were in place. This was good practice. However, the action plan did not deal with the issue of care providers' reticence about using fire retardant sprays, and the need for fire preventative/limitation measures, such as the provision fire retardant bedding. The request for a mobile sprinkler does not appear to have resulted in one being provided. Some local authority social services or housing departments have their own mobile sprinklers which they can deploy to individuals with care and support needs who smoke and present a fire risk. There was a suggestion that DJT might change from cigarettes to vaping to reduce the risk of burns to himself from hot ash dropping from his cigarette, and to reduce the fire risk, but this was not until April 2021.

9.13.11. For the future, to provide a greater level of fire protection to residents who smoke and to their neighbours, referrals for fire risk assessments should be timely and the scope and range of fire protection measures should be reviewed.

9.13.12. Two further developments that have taken place after DJT's death are that the West Sussex Safeguarding Adults Board holds a fire safeguarding meeting once a quarter as part of the Multi-Agency Risk Management Subgroup (MARM) and the Adult Fire Safeguarding Development Group (AFSDG) has now held two quarterly meetings. The AFSDG meetings are chaired by the Head of Prevention at West Sussex Fire and Rescue Service.

The AFSDG is a multi-agency partnership led by West Sussex Fire and Rescue Service, to ensure that fire safety risk management is embedded in partner safeguarding, self-neglect, and assessment practices to reduce people being killed or seriously injured in fires.

9.13.13. Despite this, there remains a conflict between the information supplied to the Reviewer by the West Sussex Fire and Rescue Service and that supplied by WSCC. West Sussex Fire and Rescue Service appear to have promoted the use of fire-retardant bedding and fire-retardant sprays, but WSCC states that this was not the case. This matter needs to be resolved and a further meeting between the two agencies should held to establish a definitive position on appropriate fire minimisation and prevention measures.

9.14. Occupational Therapy

9.14.1. Occupational therapy service became involved with DJT in May 2020 and the service suggested that WSCC complete a risk assessment score for on-going support with food preparation, shopping and cleaning. However, there does not appear to have been any clear functional assessment of what DJT was able to do independently and what he could do with support to take back control of his life.

9.15. Impact of Covid

9.15.1. The Covid-19 pandemic and government measures to restrict the spread of coronavirus during 2020/21, linked with DJT's disability, had a negative impact on some agency's abilities to engage with DJT.

9.15.2. From 6th March 2020 AWC was providing a social prescriber service to DJT. The aim of the service was to talk through issues and concerns with DJT and to help him get the right advice and navigate local support services that could benefit him. With the onset of the Covid pandemic in the UK and the introduction of government measures to restrict the spread of Covid-19, prescriber staff and clients were transferred to a "connector service". It is not clear exactly how the connector service differed to the social prescriber service, but face-to-face meetings with clients were discontinued from 24th March 2020 and were not reintroduced until 20th August 2020.

9.15.3. In the meantime, telephone calls were substituted for face-to-face meetings, and this proved difficult especially when DJT did not answer telephone. This may have been due to DJT being unable to find his telephone or being intoxicated.

9.15.4. AWC has described the Covid-19 pandemic as having a major impact on the service they were able to provide. Restrictions on seeing people in person made it difficult to offer support, especially for those clients who had disabilities, and for people with visual impairments in particular. For someone who struggled to use his telephone, only having telephone options for support was extremely difficult for DJT. AWC referred DJT on to specialist services. However, these services attempted to contact DJT by telephone and left voicemails messages or sent texts that DJT was not able to see or access. Services then closed DJTs case due to non-engagement. Practitioners from AWC are of the view that had they been able to support

DJT to contact services in person, there may have been a different support outcome from some of those services. The Benefits Office were not able to offer any face-to-face appointments which further frustrated attempts to claim benefits.

9.16. **Handling of safeguarding cases**

9.16.1. Concerns in July and August 2020 about the failure of Care Agency 1 to meet DJT's needs were handled under the quality issues pathway procedures rather than under safeguarding procedures as neglect. The concerns were not submitted to or discussed with the safeguarding hub, as the Pan Sussex Safeguarding Adults Threshold document document requires.

9.16.2. Responses to Freedom of Information requests and other enquiries to a local authority may give the impression that the local authority is failing to initiate S42 enquiries when it handles such matters under procedures other than safeguarding, even if those other procedures are appropriate in the circumstances. It is therefore important to follow WSCC's own procedures and submit a referral for safeguarding when the thresholds are clearly indicating that this was appropriate. This would have resulted in the safeguarding consideration and decision being recorded.

9.16.3. On 17th February 2021 a safeguarding concern, received by WSCC from SECAmb on 10th February 2021, was entered onto WSCC's social services computer system, Mosaic. The concern was noted as meeting criteria for a Section 42 enquiry for self-neglect and then closed off as "No Further Action". The referral had been sent by SECAmb as an open case contact to DJT's allocated team, which did not then follow WSCC's safeguarding process. Had the contact from SECAmb been understood as an adult safeguarding matter, a referral should have been made to the Safeguarding Hub rather than closed at this point.

9.16.4. According to WSCC, the safeguarding enquiry did not need to remain open as it was being handled under the Self-Neglect procedures. Closing a safeguarding enquiry off as "No Further Action" is potentially misleading and does not give assurance that action is being taken. An internal review of DJT's case has recommended the development of a process for logging and monitoring cases being managed under the Self-Neglect procedures on Mosaic.

9.17. **Good practice**

9.17.1. On 6th April 2020 DJT was found by officers of Sussex Police three times in one day. He was disorientated and told officers he was looking for the village shop. Sussex Police then drove DJT to the shop and then home. At this time DJT was not receiving a care package. Sussex Police found DJT's studio flat was extremely untidy and dirty, there was rubbish all over the floor and surfaces, there were pots and pans sitting dirty in the sink and barely any food. The bathroom was extremely dirty with faeces all over the toilet and ash all over the sink. Sussex Police stayed and cleaned the flat for DJT. They removed six bags of rubbish, put his sheets in the wash for him, washed all his dishes and cleaned the surfaces. In total they spent one hour

at the property trying to tidy it up for him because of the state it was in. Clearly this was not within Sussex Police's remit, but they recognised DJT's disability and need for help.

9.17.2. ROVI provided significant support to DJT to help him cope with his sight loss, and in resolving issues in relation to finances, together with emotional support over the loss of his son and breakup of his marriage.

9.17.3. As well as Sussex Police input and the substantial support provided by ROVI, practitioners reported that other agencies went above and beyond their remit, for example, two representatives from WSCC supported DJT by accompanying him to several banks to help sort out his finances and AWC also spent a considerable amount of time trying to resolve DJT's benefit issues. WSCC, AWC and other agencies planned a comprehensive package of support for DJT to help him move and settle into his new flat in December 2020. A representative from WSCC Extra Care visited DJT every day and tried very hard to engage with DJT and interest him in trips out of the flat, such as inviting him out for a coffee, but DJT refused. He told the worker to leave him alone. The worker believes that DJT was embarrassed about not looking after himself and that this contributed to his refusal of support and offers to go out.

10. Recommendations

10.1. Recommendation 1: West Sussex should reinforce with its staff the distinction between abuse and neglect and poor quality of service. The Pan Sussex Safeguarding Adults Threshold document which supports staff in identifying potential safeguarding matters and referral processes should be followed.

10.2. Recommendation 2: The SAB should seek assurance that all staff are able to follow the Pan Sussex Safeguarding Adults Threshold document and are aware of how to refer appropriate safeguarding matters to the safeguarding adult hub.

10.3. Recommendation 3: WSCC should obtain a definitive opinion on data protection legislation and how this interacts with supporting adults with bills, correspondence, and technology. This will enable WSCC to be active and authoritative in requiring care agencies to revise their practice underpinned by and supported with a correct interpretation of the law.

10.4. Recommendation 4: WSCC should explore with the Benefits Office how they may work in partnership with agencies such as adult social care to improve the client experience for those with disabilities.

10.5. Recommendation 5: Partner agencies should promote the use of multi-agency meetings and the identification of one professional to coordinate agencies and their response to clients with complex needs.

10.6. Recommendation 6: Partner agencies should consider revising or supplementing the Sussex Multi-Agencies Procedures for Adults who Self-Neglect to include more recent guidance from Braye, Preston-Shoot and Orr and include reference to multi-agency meetings where people are self-neglecting by not managing their finances and are prioritising the purchase of alcohol over buying food and paying utility bills.

10.7. Recommendation 7: Partner agencies should consider whether the presence or suspicion of self-neglect should give rise to an assessment of an adult's mental capacity to decide on their care and support needs and where they live. Partner agencies may choose to amend the Sussex Self-Neglect procedures accordingly.

10.8. Recommendation 8: Partner agencies should promote the use of trauma-informed approaches to supporting adults who have experienced trauma.

10.9. Recommendation 9: Where an adult expresses suicidal intention or has attempted suicide, all agencies should ensure that the adult has been offered an opportunity to complete a NICE compliant, co-produced, suicide safety plan. For agencies that do not deliver care or support, this means ensuring that an adult is offered a referral to a service that can offer such an intervention.

10.10. Recommendation 10: Partner agencies should ensure that triggers are in place to make referrals for fire risk assessments as soon as concerns for fire safety are identified.

10.11. Recommendation 11: As well as fire safety meetings implemented by the West Sussex Safeguarding Adults Board and the AFSDG, WSCC, in consultation with West Sussex Fire and Rescue Service, should consider whether there are other fire protection and minimisation measures that could be employed and how any barriers to implementation can be overcome.

10.12. Recommendation 12: The West Sussex Safeguarding Adults Board should seek assurance from the Integrated Care Board on measures taken to promote public awareness and empowerment on how to access support to meet their medication care needs, particularly when an adult cannot access over the counter medications and when a carer is required to administer medication.

10.13. Recommendation 13: The West Sussex Safeguarding Adults Board should seek assurance from the Integrated Care Board on measures taken to promote public awareness and empowerment on how to access support to meet their medication care needs, particularly when an adult is not entitled to free prescriptions, and cannot afford to pay for prescriptions, to enable them access to the essential medication they need.

11. APPENDIX A – DJT'S SIGHT LOSS, CHRONOLOGY, DESCRIPTION AND TREATMENT

11.1. DJT suffered an accident at work on 13th November 2019 where something penetrated his eye. It is not clear from the GP records (and during the course of this SAR the GP surgery has been unable to confirm) whether this was in his right or left eye, but it appears that over time he suffered deteriorating sight in both eyes, and that he developed glaucoma in both eyes. DJT attended Worthing Hospital Accident and Emergency Department on 13th November 2019, but he does not appear to have been referred to specialist eye services at that point.

11.2. On 13th February 2020 DJT visited his GP with red and itchy sclera (the white part of the eye) in both eyes and was prescribed eye drops for eye infection. Then on 17th February 2020 his GP made an urgent referral for an ophthalmology appointment.

11.3. DJT attended an appointment with one of the ophthalmology clinics run by University Hospitals Sussex NHS Foundation Trust on 20th February 2020 and then he was referred onto another clinic at which, on 25th February 2020 DJT was diagnosed with chronic closed-angle glaucoma in both eyes, and on 2nd March 2020, having attended a London eye hospital, he was "Registered Blind" with WSCC. Presumably this means he was registered as "severely sight impaired" rather than "sight impaired".[5]

11.4. In secondary closed-angle glaucoma, an underlying condition causes changes to the eye that force the iris against the trabecular meshwork. These conditions include eye injury.

11.5. Closed-angle glaucoma leads to an increase in eye pressure. The increase in pressure damages the optic nerve, which affects sight. Any resulting sight loss is permanent and irreversible. Therefore, the main focus of glaucoma medical interventions is to reduce eye pressure or maintain a reduced eye pressure to prevent further sight loss from occurring. This may be achieved by the use of eye drops and/or surgery.

11.6. According to WSCC DJT had eight percent remaining vision in early April 2020. On diagnosis of glaucoma DJT was issued with a prescription for eye drops to help reduce the pressure in his eyes. However, DJT could not afford to pay for the prescriptions. On 9th April 2020 DJT had an operation to extract the lens of his right eye. According to the GP records this was because his sight had deteriorated due to him not using the eye drops.

11.7. Subsequent to this DJT attended ophthalmology appointments on 20th May 2020, 17th March 2021 and 7th May 2021. An ophthalmologist recorded DJT in March 2021 as having advanced glaucoma with no light perception in either eye.

12. APPENDIX B: MENTAL CAPACITY ACT 2005

12.1. The Mental Capacity Act requires a three-stage test of capacity to make decisions:

12.2. Is the person unable to make the decision? i.e., are they unable to do at least one of the following things:

- Understand information about the decision to be made, or
- Retain that information in their mind, or
- Use or weigh that information as part of the decision-making process, or
- Communicate their decision (by talking, using sign language or any other means)

12.3. Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors such as alcohol or drug use?

[5] RNIB, 'Registering as sight impaired'

12.4. Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to? Individuals can lack capacity to make some decisions but have capacity to make others, so it is vital to consider whether the individual lacks capacity to make a specific decision at a specific time.

13. APPENDIX C BIBLIOGRAPHY

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