



# Safeguarding Adults Review

A Report commissioned by Essex  
Safeguarding Adults Board into the case of  
Frank, a 55 year old male who died in  
March 2018

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## Introduction and Scope of Review

### 1. Introduction

- 1.1. This Safeguarding Adults Review (SAR) was commissioned by Essex Safeguarding Adults Board following the death on the 1<sup>st</sup> March 2018 of FRANK, a 55-year-old male living in District Council 1, Essex. It considers his contact and involvement with multiple professional agencies in the years before his death.
- 1.2. The responsibility of local authorities to commission a SAR is laid out in s.44 of the Care Act 2014. This provides that a SAR will occur if the Safeguarding Adults Board (SAB) identify a case where 'there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult' and 'the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)'. In the present case, the SAB considered that a SAR was warranted due to the extensive multi-agency involvement, questions around self-neglect, and FRANK being subject to several safeguarding referrals prior to his death.

### 2. About Essex Safeguarding Adults Board

- 2.1 Essex Safeguarding Adults Board brings together representatives of the main agencies in the statutory, voluntary and independent sector, responsible for working with and providing services for vulnerable adults, some of who may be at risk of abuse.
- 2.2 The purpose of Essex Safeguarding Adults Board (SAB) SAB is to help and safeguard adults with care and support needs. It does this by:
  - a) assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance.
  - b) assuring itself that safeguarding practice is person-centred and outcome-focused.
  - c) working collaboratively to prevent abuse and neglect where possible.
  - d) ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred.
  - e) assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

### 3. About the Report Author

- 3.1. I am currently employed by the University of East Anglia as the Senior Clinical Tutor on the Clinical Psychology doctoral training programme. I have held this role since September 2016. I am additionally an Honorary Consultant Clinical Psychologist with Norfolk and Suffolk NHS Foundation Trust (NSFT).

- 3.2. Prior to my current role, I was employed by Mental Health Trust as the Head of Secure Services Inpatient Psychology. I worked for Mental Health Trust from 2009 until July 2016, originally as a Clinical Psychologist, and as a Consultant Clinical Psychologist from June 2014.
- 3.3. My primary clinical experience is in working with offenders with mental health problems, typically detained under the Mental Health Act. I have extensive experience in assessing people with complex mental health problems and personality disorder, who have also committed various offences and/or pose a risk of violence. I have also experience in completing assessments for and giving evidence in Magistrates, Crown and Coroner's court settings. I have specific post-qualification training in the administration of a range of tools related to the assessment of risk and complex psychopathology.
- 3.4. In terms of my academic qualifications, I hold a degree in Experimental Psychology from the University of Oxford (First Class, 2005), a Doctorate in Clinical Psychology from the Institute of Psychiatry, King's College London (2009), and an LLM in Mental Health Law (with Distinction) from Northumbria University (2018).
- 3.5. In terms of my professional qualifications, I am a chartered member and Associate Fellow of the British Psychological Society (BPS). I am a registered Practitioner Psychologist with the Health and Care Professions Council (HCPC), the legal body that regulates Practitioner Psychologists in the UK. I am in good standing with both organisations.
- 3.6. Of relevance to the present report, I note that I do not have any specific medical expertise – I am not a medical doctor. Therefore, my commentary on aspects of Frank's physical health, e.g. the impact of alcohol on his physical status – is limited to being able to repeat information expressed in other reports.

## 4. Method of Review

- 4.1. The primary purpose of a SAR is to learn lessons and improve practice, so that care and professional input in future cases can be improved. Given the wide-ranging involvement of a number of agencies in Frank's care, the SAB held a Practitioner Learning Event on the 28<sup>th</sup> September 2018, with front-line practitioners being invited to attend from all agencies that had had contact with Frank. A second learning event was then held on the 29<sup>th</sup> October 2018 with managers from the various organisations that had been involved in Frank's care and treatment.
- 4.2. The purpose of the events was to assist staff – including practitioners, managers and commissioners – who had either directly worked with Frank, or who worked in services where Frank had received care, to develop a wider understanding of the events that had led up to his death, and to consider lessons for future practice. The aim was not to hold practitioners or organisations to account, or to attribute blame.
- 4.3. This SAR report brings together much of the learning that was identified at the both learning events (much of the history is influenced particularly by the Practitioner Learning Event, which was attended by a number of practitioners who had worked directly with FRANK; much of the learning was influenced by discussion at the manager's learning event), as well as collating and summarising the historical input from the various agencies who were involved in addressing Frank's care, housing and social needs. This input was collated by the SAB through a multi-agency chronology collation exercise. Chronologies were requested for the last two years of

Frank's life, to ensure that the learning outcomes were likely to reflect contemporary practice. However, during the Learning Workshop, further historical information relating to Frank's contact with services was shared leading to a clearer understanding of some aspects of Frank's earlier developmental history and time in the UK before moving to District Council 1. In particular, the housing agency who worked with Frank up until his eviction in 2016 were able to share wider historical information which has helped inform our understanding of the broad chronology of Frank's life which helped contribute to the understanding of Frank's lived experience.

4.4. The chronology considered by the report author includes information from the following agencies:

- District Council 1
- District Council 2
- Local Homeless charity
- Housing Association
- Drug and Alcohol Services
- Essex Police
- Essex County Council
- Clinical Commissioning Group
- Local Hospital Trust
- Mental Health Trust

4.5. It is noted that not all information which could have informed the report was necessarily included in this chronology. For instance, records from mental health services had not been obtained, and only a summary GP record was obtained. Some further information was requested by the report author, although not all of this was able to be made available. Of course, the report is limited to the extent that it can only consider information available and it is possible that further information coming to light from other agencies may affect conclusions and recommendations made.

4.6. The following agencies attended the Learning Workshop:

- District Council 1
- District Council 2
- Local Homeless charity
- Housing Association
- Drug and Alcohol Services
- Essex County Council
- Clinical Commissioning Group
- Local Hospital
- Mental Health Trust

4.7. In addition, the Independent Reviewer made contact with Frank's brother by email in order to ascertain his views and allow his input into the SAR process (his email address was provided by the coroner to the LSAB for the review process). At the point of writing this report, Frank's brother has not responded to these emails.

## 5. Key Areas of Learning for Consideration

5.1. The key questions to be considered by the present report are broadly:

- Was there was anything that services could have done which could have prevented Frank's death?
  - Were Frank's health and care needs were met adequately whilst he was alive?
  - What were the safeguarding concerns in Frank's case, and were these responded to appropriately?
- 5.2. Given the large number of agencies working together in the care of Frank, the report will also consider the following additional question:
- Did agencies work together effectively to allow Frank's health and care needs to be met?
- 5.3. In considering these questions, the report will specifically focus on the following key areas:
- Housing provision and Frank's homelessness
  - Alcohol
  - Mental Health
  - Physical health
  - Aggression and violence

## Case Information

### 6. Summary of Case

- 6.1. Frank died on the 1<sup>st</sup> March 2018. At the time of his death he was living temporarily in XYZ Hotel in District Council 1. He had been placed at XYZ Hotel due to the council's cold weather provision, which activates after three consecutive days where temperatures are below 0°C. An Inquest conducted by HM Senior Coroner for Essex, Mrs Caroline Beasley-Murray, concluded that the medical cause of death was Multi-Drug Toxicity with a background of Liver Cirrhosis. An open verdict was recorded by the coroner.
- 6.2. In the latter years of Frank's life, Frank presented with a range of care and social needs. He had been made homeless in September 2016 after being evicted from his tenancy in the Dunmow area. He would remain homeless until his death. The eviction had occurred in the context of significant antisocial and violent behaviour. The records indicate that shortly after his eviction, Frank relocated to the District Council 1 area, but the reasons for this are not fully clear. From September 2016, Frank remained homeless, with occasional periods of being housed temporarily in hotels, and, since at least August 2017, Frank was living in a car outside a supermarket. Over this latter period of Frank's life, it is recorded that Frank was befriended by a number of people in the community, including, it appears, somebody who sought to record videos of Frank for the reported purpose of making a documentary. Concerns were raised at the Professionals' Learning Event about Frank's vulnerability in relation to this person.
- 6.3. Records surrounding Frank's life and circumstances prior to his eviction were limited in the chronology, reflecting the fact that professionals working with Frank in the latter stages of his life – after his move to District Council 1 – did not have much knowledge of these factors. As an example, it is noted, for instance, that Frank's place of birth is generally recorded as Iraq by agencies working with him in the last two years of his life, when earlier records give this as Tehran, Iran.



- 6.4. Many of Frank's difficulties are attributable to his significant long-standing problems with alcohol, which likely included physical dependence. He had experienced a number of blackouts and seizures which had necessitated emergency hospital treatment in the years prior to his death. Although alcohol use was consistently high it is believed to have escalated further in the months prior to his death. He may have also used other drugs but this is not clear. It seems likely that alcohol use was in some way related to underlying mental health problems, which is recorded consistently in the available records as Post-Traumatic Stress Disorder (PTSD), and apparently related to experiences most likely during the 1980-1988 Iran-Iraq war, but also potentially exacerbated by an assault experienced in Bristol around 2009. He received some supportive psychological treatment focused on his alcohol abuse, but never for PTSD. Finally, all of this was in the context of a background of poor physical health generally; whilst homeless he was treated for frostbite on more than one occasion, and his GP records him as having diabetes, pancreatitis, cirrhosis of the liver, and hypertension.

## 7. Frank's Lived Experience

- 7.1. This section considers Frank's lived experience primarily after being evicted from his housing tenancy on the 15<sup>th</sup> September 2016. A summary of known information about Frank's lived experience prior to this date can be found in **Appendix 1 - Frank's Lived Experience Prior to 2016**.
- 7.2. The process of Frank's eviction in 2016 occurred over a relatively lengthy period with significant engagement demonstrated by the housing agency (see **Appendix 1**). It is noteworthy that in June 2016, after the first possession hearing, Frank contacted the Alcohol and Drug Advice Services and began contact with a drugs worker. This involves half-hourly sessions which continued, at least on a semi-regular basis, until February 2017. The discussions during these sessions appear meaningful and although it is perhaps the case that his accommodation situation precipitated him getting in contact with the Drug and Alcohol services team, Frank does continue to maintain contact after being evicted and the notes suggest he appears to derive benefit from these sessions. The approach used, Motivational Interviewing (MI), is clearly appropriate to the case. Fundamentally, MI assumes that people who present with drug or alcohol problems are typically in a state of ambivalence; often having strong reasons or desires to both change/reduce their alcohol use, and also to maintain it.
- 7.3. It appears that after being evicted, Frank was initially homeless in Dunmow, and his housing needs were reviewed by District Council 2. It is not completely clear when Frank actually moved from District Council 2 to District Council 1. He is noted to have attended several appointments there in late 2016, and is housed (temporarily, by District Council 2) in the XYZ Hotel (the same hotel in which he died) in October 2016, after an episode of frostbite. It is recorded that he was evicted from this temporary accommodation later in November after an episode of antisocial behaviour – but the details of this are not known. Frank's narrative of this, relayed in a meeting to the Citizen's Advice Bureau, is that he was 'asked to leave after complaining about the facilities'. After being evicted and being street homeless, Frank experienced a chest infection and hypothermia, requiring hospital treatment. He was subsequently rehoused temporarily at another hotel in the Dunmow area, staying there until February 2017. During this period, District Council 2 identified some potential accommodations options, but these were not accepted by Frank either due to their

location or other factors (e.g. one being dormitory accommodation). On reflection, one might hypothesise that dormitory accommodation may have been particularly problematic for Frank in the context of his PTSD. One potential option identified by District Council 2 in February 2017 is also discounted as the provider indicates that Frank's mental health needs are 'too high'. Another possibility is discounted because of the history of antisocial behaviour. Ultimately, District Council 2 are recorded as concluding that 'all options have been exhausted', suggesting that Frank tries to identify an out-of-area private rental property.

- 7.4. Frank is required to leave the temporary accommodation identified for him towards the end of February 2017. Within two weeks, it is recorded that Frank is again admitted to hospital with frostbite. It is understood that Frank remained homeless during this time. In June 2017, it is recorded that Frank then applied to Chelmsford City Council as homeless. A few days later, in early July 2017, there is an incident where Frank is then arrested following offences of assault and criminal damage. The circumstances are not completely clear but the criminal damage occurs to an ambulance. It is further noted that whilst in police custody, Frank then assaulted the custody sergeant whilst being transferred between cells. This leads to Frank receiving a community order with an alcohol treatment requirement.
- 7.5. Four days later, on the 6<sup>th</sup> July 2017, Frank presented at District Council 1 for the first time claiming to have been street homeless in District Council 1 for the last nine months. Clearly, over this time, there has been some movement by Frank around the various localities. As noted previously (7.3), District Council 2 had taken responsibility for seeking accommodation options and provision of temporary hotel accommodation up until this point. After Frank approached District Council 1 however, District Council 1 contacted District Council 2, who send them their correspondence in relation to Frank's case. From this point District Council 2 no longer have active contact with Frank. District Council 1 interviewed Frank and issued him with paperwork, including a medical form. This is noted as never having been returned to the council by Frank. It appears that as a consequence District Council 1 do not take up Frank's case and this transition means that active attempts to seek accommodation for Frank stop (although it is also noted that, by this stage, District Council 2 felt they had exhausted all possible alternative accommodation options). The fact that Frank declined to go to hostel accommodation is noted, presumably implying that Frank chose not to accept a reasonable offer of accommodation. Effectively, the transfer from District Council 2 to District Council 1 means that Frank's case is closed to District Council 2, whilst at the same time he is not taken on by District Council 1.
- 7.6. By August 2017, Frank is recorded as living in the woods near a supermarket in District Council 1. This is the same supermarket that Frank would then live outside, in a car, until his death. On the 15<sup>th</sup> August 2017, it was recorded that a 999 call was made after Frank was found collapsed and intoxicated. The notes record that Frank was taken to hospital by ambulance for treatment, but was then aggressive and violent towards staff at A&E. Police were called and a police officer was then assaulted. The records indicate that Frank may have had other admissions to hospital in the following days, but it is not clear if these records relate to the same event. In September 2017, it is also important to note that Frank initiated contact with the CDAS service, initially stating that he was ready for an alcohol detox.
- 7.7. During this period, Frank began to develop (and subsequently maintained) contact with a number of statutory and non-statutory agencies – many of whom were part of the learning event. This included a Local Homeless Charity and Drug and Alcohol Services. These agencies provided Frank with support for a range of day-to-day needs and were a source of regular contact with Frank. There is a further episode of



an assault, and a concern about Frank being 'drunk in charge' of a vehicle (one of the professionals who attended the learning event noted that Frank had arranged so that although the car's engine could be started, and the heating activated, the car could not be driven, so that he would not be tempted to do so when intoxicated; the offences related to him being in the vehicle or with the engine running whilst intoxicated). In October, there was an episode recorded where he had been victimised by a group of youths, but on the whole, there was a consistent view that during this time Frank struck up and developed relationships with a number of people in the community, particularly including those who worked in the businesses nearby. It was noted, for instance, that he would be given food by people working in the area.

- 7.8. There was some evidence during this time that Frank expressed some ambivalence about living, and some evidence of suicidal ideation. For instance, in November 2017 – the day before Remembrance Day – he had told one of the workers from Drug and Alcohol Services that he hoped to 'join his comrades' at 11am the following day. It was noted that Frank 'has been known in the past to make threats to take his own life. but history has shown that this is usually to gain access to hospital treatment'. Two weeks later, a safeguarding referral was made following a 999 call after becoming intoxicated and saying "he doesn't want to be here any more". Notably, the ambulance log also gave an indication of the degree to which Frank's physical health had become impacted – he was noted to have had black feet from non-management of diabetes. Further, one of the attendees at the learning event noted that in February 2018, a risk assessment had been completed indicating that Frank had been feeling 'low' but was not suicidal. However he was also noted to have been ambivalent about death – that if 'death came naturally he would be happy to take that'.
- 7.9. Indeed, during this time, it appears that Frank became a regular caller to 999 and there were multiple visits to hospital, some following episodes of unconsciousness, and some for what appears to be acute effects of unmanaged physical health conditions or adverse effects of homelessness (e.g. frostbite). By December, it was noted that he was still sleeping in his car, putting £5 of petrol in a day so he could keep the engine running to stay warm. The safeguarding concerns which were raised by the ambulance service led to a multi-agency professionals meeting on the 14<sup>th</sup> December 17. This was clearly a good opportunity for services for a wider review of the main issues in Frank's presentation. His alcohol use was reviewed, with inconsistencies between Frank's report and professionals' observations being discussed. His mental health needs were clearly noted as a significant concern. The wide range of medications being received was also noted, and there was clearly significant discussion about his housing issues and managing immediate needs over the winter period. A number of appropriate actions arose out of this meeting.
- 7.10. It appears that as Frank began to develop relationships with members of the community, there were also concerns expressed about his contact with a male who identified himself to professionals working with Frank as a journalist and advised that that he was making a documentary about Frank. It transpired that this person had done some fundraising on Frank's behalf and used these funds apparently for Frank's benefit, for instance ordering pizza to be delivered to his car, as well as occasionally hotel rooms for his benefit. Although professionals involved acknowledged the benefits to Frank, concerns about this person were exchanged between professionals. It was known that this person had previously made a documentary about another service user known to them and there were some concerns this person had taken advantage of some of their vulnerabilities.

- 7.11. In January 2018, after initial contact some months previously, Frank again began regular meetings with the CDAS service. On this occasion this appears to be related to an Alcohol Treatment Requirement as part of his probation conditions. However these sessions still seem to have led to meaningful engagement and discussion. As previously, these were delivered using a Motivational Interviewing Framework. Notes from these sessions were clearly documented. Self-reported consumption of alcohol was regularly monitored and showed continued hazardous drinking with episodes of further escalation. His physical health appeared to deteriorate further. During a meeting with CDAS on the 31<sup>st</sup> January 2018, it was noted that 'he had collapsed once already this morning', and that he was concerned about his blood pressure being high. A week later, on the 8<sup>th</sup> February 2018, there was another 999 call documented following a fall and Frank experiencing breathing difficulty whilst in Chelmsford. The ambulance notes recorded 'Chest infection, non-compliant with medications and multiple seizures every week for a number of years'. The following day he was recorded by Drug and Alcohol Services as 'shaking uncontrollably'. Despite this, Frank had not yet registered with a GP in District Council 1 – although he had been provided with paperwork to do so. He had been sleeping in a friend's shop at this time.
- 7.12. The prompting does lead to Frank to register with a District Council 1 based GP practice and a few days later he attends his first GP session. It appears that he uses this session to request diazepam, which is denied.
- 7.13. Two days later (16<sup>th</sup> February 2018), Frank's case was reviewed at a multidisciplinary meeting at Local Hospital Trust. The purpose of this meeting was to review frequent attenders at A&E, and it is therefore presumed that this meeting was not called specifically for Frank but that he was one of a number of people being reviewed regularly by the multiple agencies. Notably, representatives from mental health services were present at this meeting, although to this point it does not appear that statutory mental health services had had any formal input in Frank's care or treatment. Those at the meeting appeared to form the view that there was a connection between Frank's PTSD and some of the aggressive and violent being observed when Frank was admitted to A&E: 'he has problems with people in authority such as security guards etc. as they trigger flashbacks and has been arrested for violent outbursts in the past'. However, this did not lead to any formal assessment or referral for mental health difficulties. The care plan was that if Frank presented at A&E without physical health symptoms, he would be referred directly to CDAS. There does not appear to have been any other plan developed for managing his presentation when physical health needs are required to be addressed, and the only suggestion for managing mental health was to provide Frank with details of a charitable organisation for veterans who might have provided support (at the learning event it was agreed that Frank would not have met eligibility criteria for this organisation).
- 7.14. In the final two weeks of Frank's life, the records available do not suggest that there is any significant change in professionals' engagement with Frank or their concerns about him. He has a further GP review, which does not make any significant observations; he continued to meet with CDAS and was noted to have shown a small reduction in alcohol use; he was recorded as making use of cold-weather provision (temporary accommodation in XYZ hotel) where this was available. He had been banned from sleeping in some of the churches in the area due to his alcohol use. A plan was developed to refer him back to District Council 1 Housing, noting that his diabetes may have made him a priority (though a change or progression in this long-standing condition is not observed). The exact circumstances surrounding the reporting and discovery of Frank's death are not fully clear, but one note indicates that concerns were raised by a Local Homeless Charity with the police. An

ambulance was called who recorded an 'obvious death' on arrival. Another note indicates that Frank's body may not have been found for a day or two.

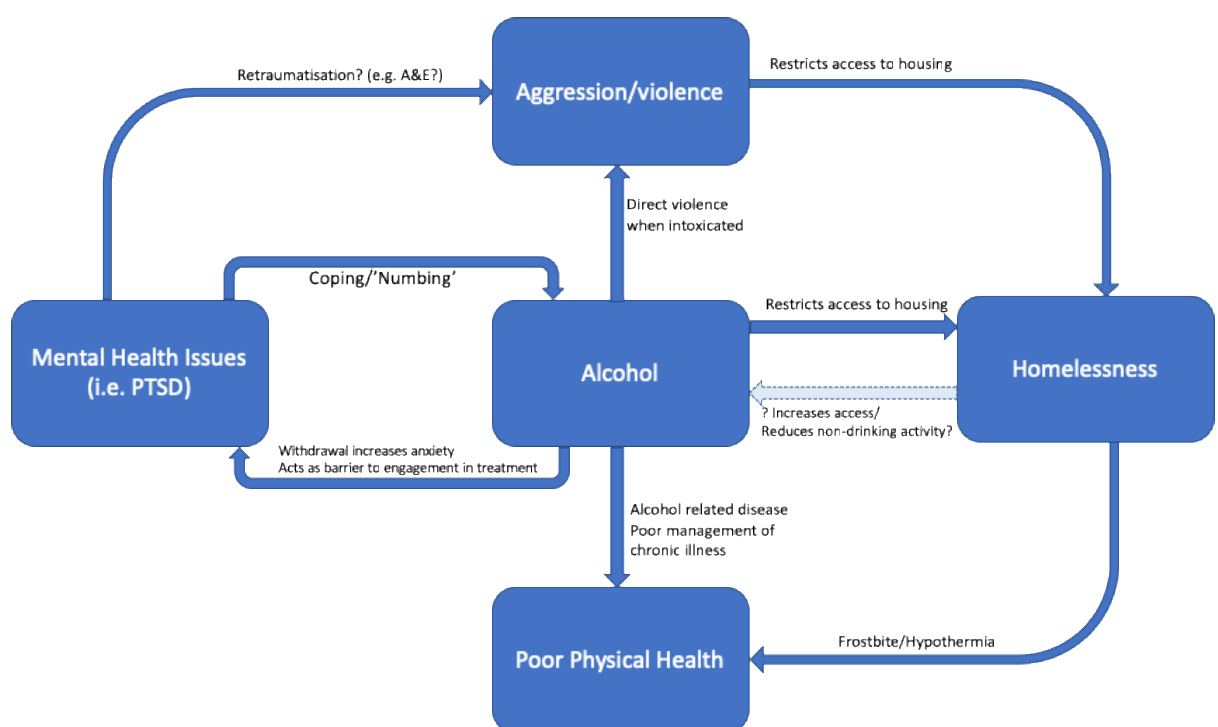
## Analysis

### 8. Key Areas of Learning

#### Could Frank's death have been prevented?

- 8.1. Through a review of the available case material, it is hard to see how Frank's death could have been prevented by different action taken by professionals in the weeks and months prior to Frank's death.
- 8.2. Whilst it is not the role of the present report to make any formal determination as to the cause of death, it seems likely that Frank's death was an end result of a culmination of increasingly poor physical health in the context of chronic alcohol use and dependency. This conclusion reflects the coroner's verdict. Further, the possibility of wider drug use, as well as an escalation in alcohol use precipitating the death is also noted.
- 8.3. Of course, the above conclusion does not mean that there are not many points in Frank's care pathway during which care could have been improved and these factors do form part of the learning identified in this report. However, we do not know to what extent such changes would have ultimately led to a different outcome for Frank.
- 8.4. In trying to identify the factors which might have been most likely to have contributed to a different outcome for Frank, it makes sense to first consider those factors most closely related to the cause of death. The most prominent of these factors appear to be his poor physical health and chronic alcohol use. In this regard, one might make a number of observations. First, poor physical health was likely worsened by Frank's poor self-management of chronic medical conditions, non-engagement with medical care, and inconsistent use of medication. Of course, alcohol use is itself likely to have also had a significant impact on Frank's poor physical health – both directly (e.g. through alcohol related disease), and also indirectly, by reducing effectiveness and compliance of medical treatment in relation to his other chronic conditions. It is also likely to have contributed towards his homelessness, by reducing housing provider's choices in regards to offering Frank suitable accommodation. In turn, homelessness also appears to have contributed to Frank's poor physical health, with a number of his conditions (e.g. frostbite) being directly related to chronic experiences of cold conditions.
- 8.5. However, Frank's poor physical health and alcohol use were not factors which existed in isolation or without cause. Indeed, it seems that Frank's poor mental health – and specifically PTSD - may be the most likely candidate for a 'distal' cause of all of these issues. Certainly, chronic alcohol use can potentially be understood as a potential coping mechanism for anxiety or flashbacks/re-experiencing as a result of PTSD. Furthermore, withdrawal from alcohol (which appeared to occur when Frank ran out of money, or perhaps in specific situations such as during admissions to hospital) would have then increased anxiety beyond that attributable solely to his PTSD. Mental health issues may also have had an impact directly on homelessness; it was hypothesised at the manager's learning event that the environment of a car may have felt a 'safer' place for him to reside (noting the records suggesting that Frank had experienced flashbacks in his own bedroom when he did have a house).

- 8.6. Mental Health problems may also have directly contributed to aggression and violence, potentially in the form of re-traumatisation during experiences in relation to engagement with authority figures (e.g. police officers, security guards at A&E). It also appears to have been a contributory factor in at least some of the antisocial behaviour (e.g. that which contributed towards his eviction). His tendency to respond to anxiety using violence may also have been influenced by his military background and training. But aggression and violence was also, at times, most likely attributable to the direct result of intoxication from alcohol.
- 8.7. Although this is likely to be a partial or incomplete understanding of the maintenance of Frank's problems, these factors as outlined might be illustrated most clearly in the following diagram:



### Were Frank's health and care needs fully met?

- 8.8. In considering the relevant factors in the above diagram and narrative, one might summarise the nature of care and support provided by involved services:

- *Homelessness*

- 8.8.1. Significant effort was made by third-sector organisations working with Frank to provide support during his period of homelessness. Significant efforts were made by District Council 2 to locate and source appropriate accommodation for him. These efforts were not continued by District Council 1 as he was not taken on by them. Although Frank was not taken on by District Council 1, it seems that many options – beyond private renting for accommodation – had been exhausted by this stage. Housing providers spoke of the need to offer accommodation which responded to his other needs (particularly mental health and alcohol) and

which was also able to work with his challenging behaviour. It does not appear that housing providers had access to any accommodation which would address these various needs.

- *Alcohol*

8.8.2. In relation to his alcohol use, Frank received significant input from CDAS which was appropriate and appeared of a high quality. However this did not link back to Frank's mental health issues, which were in turn likely maintained his alcohol use. Provision of input for Frank's mental health needs was beyond CDAS' remit. Unfortunately, Frank's alcohol use also worked as a barrier for Frank to engage in meaningful work to address his mental health needs.

8.8.3. It is noted that Frank was never offered detoxification from alcohol (according to the information available on the chronology). NICE guidance<sup>1</sup> makes clear that this should have been considered in Frank's case. This guidance indicates that, amongst other groups, those people using between 15-30 units of alcohol a day and with associated mental health difficulties should be considered for residential or inpatient assisted withdrawal, with a lower threshold being suggested for people who present with other vulnerabilities such as homelessness. Although Frank sometimes reported his alcohol use to be lower than this threshold, this was regularly questioned by practitioners working with Frank. It seems reasonable to conclude that these criteria would have likely applied in Frank's case.

8.8.4. It is clear that Frank's ambivalence about alcohol use fluctuated and there would have been times when he may have been more or less likely to accept or seek this out. Further, it is likely that in Frank's case, long term reductions in alcohol use or abstinence would not have been achieved without meaningful mental health input (see comments below).

- *Aggression and Violence*

8.8.5. In relation to his aggression and violence, Frank received monitoring and input from the CRC post-conviction. Responses to this by police and A&E appear appropriate given the level of risk/distress associated with his behaviour. However it does appear that staff working in this setting may have been unaware of the potential for Frank's mental health issues to impact on or indeed direct his violent behaviour viz. re-traumatisation. It is unlikely that such information would have changed their response in the immediate situation, but it may have allowed a more planned approach to managing Frank – for instance by the multi-disciplinary review for frequent attenders.

- *Physical Health*

8.8.6. Frank was a frequent user of both ambulance services and A&E. There is nothing to suggest that the provision of care from either service was less than adequate. It is acknowledged also that A&E and ambulance staff must have experienced a significant amount of challenging behaviour towards them when caring for Frank.

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<sup>1</sup> Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, National Institute for Clinical Excellence (2011).

8.8.7. Frank did receive, however, only infrequent reviews from his GP, despite experiencing a range of chronic physical health conditions. Of course, Frank did not appear to reliably seek out such support or contact. It is unclear why this was the case. One factor that may have complicated the situation was that Frank was not registered with a local GP in District Council 1 for some time. Frank's chaotic life situation will also have contributed. Had it been possible to offer more assertive input at a primary care level, this may have worked to prevent some of Frank's hospital admissions. It may also have contributed to referral of safeguarding concerns viz. the impact of Frank's poor management of his physical health conditions on his physical health.

- *Mental Health*

8.8.8. The records shared with the safeguarding board appear to indicate that Frank did not receive any substantive input for his mental health condition in the years immediately prior to his death. Specifically, it does not appear that he received any specialist assessment of mental health needs by Mental Health services in the local area, contrary to a clear NICE recommendation for this to occur for people where there are 'clinically important symptoms' of PTSD,<sup>2</sup> and there is no evidence that he received any evidence based psychological treatments for PTSD (again, despite clear NICE recommendations that such treatments should be offered).<sup>3</sup> It is noted that Frank did receive a psychiatric assessment in relation to his court hearing for eviction from his house, but this has not been reviewed and it is not clear whether this was privately commissioned or completed by the local mental health trust.

8.8.9. The lack of input for his mental health problem is notable and appears a significant potential missed opportunity for intervention. In this regard, it is worth noting the specific NICE (National Institute for Health and Care Excellence) guidance in relation to alcohol use which presents in the context of PTSD:

8.8.10. *"Many patients with PTSD misuse both alcohol and a range of drugs in an attempt to cope with their symptoms, and treatment of their PTSD symptoms will help them with reducing their substance use. However, if substance dependence (i.e. withdrawal symptoms, tolerance) has developed, this will need to be treated before the patient can benefit from trauma-focused psychological treatments. In cases where the drug or alcohol dependence is severe, collaborative working with specialist substance misuse services may be required.*

8.8.11. *For PTSD sufferers with drug or alcohol dependence, or in whom alcohol or drug use may significantly interfere with effective treatment, healthcare professionals should treat the drug or alcohol problem first."*

8.8.12. In the current case, however, whilst Frank did receive psychological input for his alcohol use, this does not appear to have been conducted with an overall plan

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<sup>2</sup> NICE guidance indicates that 'Assessment of people with PTSD should be comprehensive, including an assessment of physical, psychological and social needs and a risk assessment'. Note also that NICE guidance in regards to treatment tends to include reference to people with 'clinically important symptoms', indicating that whilst a formal assessment is required, a specific diagnosis is not for these treatment recommendations to apply.

<sup>3</sup> The term PTSD is used throughout this report because this diagnosis appears to be recorded clearly in the files, and it is clear that professionals working with HF reported, at the PLE, a range of significant trauma symptoms. However, it is not clear how this diagnosis was originally made.



to subsequently work with the PTSD – or to provide intervention to both presenting problems in a collaborative and joined up manner. On the presumption that provision of input for secondary care level mental health problems is the responsibility of the local mental health trust, it is this organisation that could have had the opportunity to coordinate this treatment and make a long term plan for provision of appropriate mental health treatment and support.

- 8.9. In summary, one may reasonably conclude that whilst Frank did receive input for a range of his most immediate presenting problems from statutory and voluntary/third-sector services, he did not receive any comprehensive integrated treatment for both mental health and alcohol use, which could have been provided within the context of appropriately supportive accommodation. Thus, it is reasonable to conclude that the service provision for the 'core' elements of Frank's presentation, and particularly his mental health needs, was potentially lacking.

**What were the safeguarding concerns in Frank's case, and were these responded to appropriately?**

- 8.10. From the above review, it appears that there are two broad areas in which one may have raised safeguarding concerns or queries. The first broadly relates to self-neglect: by virtue of his alcohol use Frank's physical health care was significantly impacted and he did not manage his physical health well. The second broadly relates to the potential concerns of financial abuse in relation to the community fundraising activity and money collected on his behalf.

**Self-Neglect**

- 8.11. Three safeguarding referrals were made; one in November 2016; one in September 2017 and one in November 2017. All three were made by the ambulance service. The broad nature of each referral as well as the outcomes from the safeguarding team at the local authority are detailed in the table below.

<b>Date of referral</b>	<b>Nature of concerns expressed by referrer</b>	<b>Findings by reviewer</b>	<b>Decision to proceed to s.42 enquiry<sup>4</sup></b>
3 <sup>rd</sup> November 2016	Ambulance called by police. Frank found intoxicated in street. Hypothermic. Considered vulnerable. Viewed as self-neglect. Believed adult did not continue to be at risk of harm but noted other people may be (through violence).	Visited the adult – 'no apparent care needs'; 'able to engage in GP and mental health services' – signposted.	No. Frank judged no longer to be at risk.
15 <sup>th</sup> August 2017	Frank had collapsed, taken by ambulance to Local Hospital Trust. Stating that he wished to die. At A&E became aggressive and	4 attempts made to contact Frank by telephone – no contact so referral closed.	No. Not able to contact Frank.

<sup>4</sup> Care Act 2014, s.42. This provides that the local authority should carry out an enquiry for an adult in its area 'a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it'. The purpose of the enquiry is to identify 'whether any action should be taken in the adult's case, and if so what or by whom'.

	assaulted police officer. Concern viewed as self-neglect related to alcohol use. Also noted two people with him making a documentary.		
24 <sup>th</sup> November 2017	Called 999, found 'drunk, unconscious and on the floor'. Conveyed to Local Hospital Trust. Concern again about self-neglect.	Spoke to Frank (by phone?). Frank gave overview of his situation.	No. Reasons not explicitly stated but reviewer notes involvement of several other agencies and that he had reduced alcohol consumption.

8.12. As can be seen, all three safeguarding referrals were made in good faith and flagged significant concerns about Frank's situation and ability to keep himself safe. In each case, it was judged that there was no need for a formal safeguarding enquiry under s.42 of the Care Act. Statutory Guidance<sup>5</sup> states that in cases of self-neglect, the decision 'on whether a response is required under safeguarding will depend on the **adult's ability to protect themselves by controlling their own behaviour**'. With the benefit of hindsight, and an understanding of the interaction between alcohol and mental health needs, one might reasonably reach the view that Frank's ability to protect himself was indeed not fully within his own 'control'. But reaching a determination on this question is complicated. In the present case, it is equally understandable that arguments might be found in the other direction, particularly if his consumption of alcohol was considered in isolation. These arguments, however, have perhaps been enumerated more explicitly in the process of closing the safeguarding referral and deciding not to proceed to a s.42 enquiry.

8.13. There are four further observations made of the safeguarding process in relation to potential self-neglect:

- The ambulance service was the only agency to make a referral of a potential safeguarding concern. Other agencies (e.g. CDAS in October 2016 – just prior to the first safeguarding referral by the ambulance service) flagged a safeguarding concern in their clinical records (again about potential self-neglect) but this did not lead to a referral of that concern. Other agencies also had opportunities to raise safeguarding concerns based on their observed concerns, although this was not done. Repeated safeguarding referrals may have acted as a marker of risk and therefore highlighted care needs.
- Part of the reasoning for the safeguarding referral in November 2016 to not proceed to a s.42 enquiry was that Frank was stated to have 'no apparent care needs'. It is hard to understand this reasoning in the face of the presenting mental health needs, which are then specifically identified by the professional reviewing the referral.
- Had 'care needs' been identified, s.9(1) of the Care Act 2014 would have required the local authority to conduct an assessment of those needs. Again, it is hard to understand why care needs were not identified. An assessment may have acted as to trigger professional awareness of need for wider mental health treatment.
- In the practitioner and manager's learning events, the issue of an available suitable resource to address Frank's care needs was reflected on. Again, in the November 2016 safeguarding referral, the professional identifies that

<sup>5</sup> 14.17 - <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

Frank is 'able' to engage with GP and Mental Health Services. It is important for practitioners to differentiate a person's potential or hypothetical ability to engage in a service from the availability of a resource to provide a service that appropriately addresses the underlying care needs. Practitioners should comment where there is an apparent gap between need and availability of resources to meet that need.

### **Financial Abuse**

- 8.14. At the practitioner and manager's learning events, concerns were also discussed about the possibility of financial abuse in regards to the situation where money was raised on his behalf but retained by a third party without being under Frank's control. The money was used, it is understood, to order Frank pizza to be delivered to his car, and further to occasionally pay for hotel accommodation (it is unknown how often this occurred). There had been some indication the money might have been able to be used for a deposit on a tenancy but clearly this did not occur. Concerns about this were discussed in the December 2017 multiagency meeting. It had been agreed that this would be followed through as a safeguarding referral, which unfortunately did not happen. Of course it is unknown whether, had this been referred, a s.42 enquiry would have been conducted, and if so, whether this would have led to any different outcome.

### **Did agencies work together effectively to allow Frank's health and care needs to be met?**

- 8.15. There was some evidence of effective multi-agency working, for instance a positive multi-agency meeting in December 2017, and a meeting in January 2018 via the Homeless Prevention Action Group (chaired by one of the third sector organisations), and a meeting at Local Hospital Trust in February 2018 discussing frequent attenders at A&E. There was also evidence of informal updating and communication between agencies who had already established legal contact. However, more generally, a number of observations may be made about multi-agency working in general:

- Multi-agency contact tended to occur between groups of agencies who had already worked closely in other areas or with other clients. Most agencies working with Frank had an incomplete picture of the wider range of agencies who had provided input for Frank.
- Professionals working with Frank in District Council 1 had, generally, very little awareness or knowledge of previous history which had been available (e.g. the extensive records that had been available to XYZ Housing prior to his eviction). Better understanding of the historical information may have helped practitioners better understand Frank's reasons for alcohol use and wider care needs.
- There was no 'lead' organisation or professional who took responsibility for coordinating contact between agencies.

- 8.16. Certainly, practitioners and managers at the learning events, however, reflected on the fact that there was much information 'known' in the room which they had been unaware of when working with Frank. The reflection had been that had the same discussion been had when Frank was still alive, practitioners may have been clearer about action to take in a coordinated way which might have more successfully led to some of Frank's care and support needs being adequately addressed.

## Other Observations relevant to learning

- 8.17. It is noted (6.3) that in the latter years, practitioners had recorded Frank's place of birth as Iraq as opposed to Iran. It appears that Frank was in fact Iranian. This raises a more general question as to the extent to which professionals working with Frank demonstrated wider professional curiosity as to his 'life story'. Clearly, there was evidence of this by some agencies, but this was not universal. In the Practitioner Learning Events, practitioners broadly indicated this was because of limited time they had available to work with clients.

## 9. Positive Practice Observed

- 9.1. This section is intended to record actions where professional agencies had demonstrated positive practice in regards to their input with Frank. This is not intended to indicate that agencies not identified here are considered to have provided substandard care.
- 9.2. There was good evidence that the housing provider, XYZ Housing, had managed a significant level of antisocial behaviour in a fair and ultimately robust way which ultimately led to Frank's eviction from his property. Eviction had not been sought lightly and the provider clearly tried hard to explore a range of avenues to avoid this outcome. The provider had clearly sought to interact with Frank on a very human level despite what seem to be well founded complaints by his neighbours, to whom they also owed a duty and obligation.
- 9.3. As far as can be seen, the Drug and Alcohol services provided the only consistent psychological support or service to Frank. This was in relation to his alcohol.<sup>6</sup> The input provided appeared to follow a Motivational Interviewing-based approach which is appropriate to working with alcohol use. The professionals who had contact with Frank documented their sessions carefully and identified risks and concerns, and took a number of steps to work to ensure the safety of Frank. Self-reported alcohol use was monitored robustly.
- 9.4. The ambulance service demonstrated a systematic and robust approach to reporting and escalating safeguarding concerns. Indeed, the ambulance service were the only agency to make safeguarding referrals. All of these referrals were appropriate.
- 9.5. District Council 2 are noted to have continued to make active attempts to provide housing for Frank after his eviction, and provide temporary accommodation in a hotel (for several months) in relation to physical health concerns.
- 9.6. Drug and Alcohol Services proposed a multidisciplinary meeting in December 2017 to review Frank's situation following the multiple safeguarding concerns. At this meeting, professionals were able to identify Frank's multiple needs and planned a number of appropriate follow-up actions.

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<sup>6</sup> The fact that the service by Drug and Alcohol services did not work with his mental health needs directly should not be interpreted as any criticism of Drug and Alcohol services work; such work would be outside their commissioned remit and likely their clinical expertise.

## 10. Areas of Learning and Associated Recommendations

### Provision of Appropriate Treatment

- 10.1. The first area of learning relates to the potential unmet need in relation to the provision of long-term, integrated treatment of Frank's mental health problems and alcohol dependency. This unmet need extended also to the lack of any formal assessment by mental health services of his presenting problems. This unmet need was identified at the learning event, and is echoed in the NICE guidance in relation to PTSD already cited, as well as that cited in relation to alcohol use and inpatient detoxification. There are two caveats in the identification of this need: firstly, it is unknown whether Frank would have accepted such treatment as the available records indicate that such a treatment was never offered to him or discussed (it should however be stated that he did show evidence of meaningful engagement of psychological treatment associated with his alcohol use); secondly, this need is identified in the absence of a robust clinical assessment, which may have indicated other factors which needed to be taken into account.
- 10.2. Most significantly, it appears that one of the major reasons why such treatment was not provided was that professionals working with Frank almost universally perceived that such treatment would not be available. This is despite such treatment receiving clear recommendations within NICE guidance. However, because it appears from the records available that NHS mental health services did not offer Frank a comprehensive assessment in the latter years of his life, it is unclear whether this perception is correct.
- 10.3. A further specific point is made here in that it is clear that the onus for referral for assessment of trauma symptoms is placed, in the NICE guidance, on the GP. It does not appear that the GP made a referral to secondary care mental health services. If this is the case, it is unclear why no referral was made.
- 10.4. Together, this leads to a specific recommendation:

#### **Recommendation 1**

- **The LSAB should make enquiries of both commissioners and NHS providers (i.e. the relevant CCG and mental health service) regarding the availability of appropriate treatments for both PTSD and alcohol dependence. This enquiry should specifically consider whether commissioners/providers are able to offer appropriate NICE recommended interventions to the expected population demand, namely inpatient/residential alcohol detoxification programmes for alcohol dependence, and long-term psychological therapy for PTSD (specifically CBT).**
- **The LSAB should make enquiries with the GP regarding their process for referral of patients with mental health needs to secondary care mental health services. It would be helpful to understand the reasons why a referral was not made in this case.**
- **If the process of these inquiries indicates that there is an issue with resource for provision of mental health assessment and treatment, then it is recommended that this be raised with relevant commissioning bodies. If the inquiries indicate there is an issue of awareness of resource or referral pathways (or NICE guidelines), then further training to raise awareness of services and pathways will be required.**

## **Provision of Appropriate Accommodation**

- 10.5. In Frank's case, if treatment for alcohol dependence and PTSD had been available, it is likely that such treatment would only have been successful if provided alongside appropriate, stable accommodation. This raises the question of the availability of appropriate housing to support people with complex needs like Frank.
- 10.6. Given the challenging nature of Frank's behavioural presentation and history, it is perhaps unsurprising that agencies such as 9.5. District Council 2 struggled to identify appropriate accommodation for Frank. Without appropriate treatment, these struggles were bound to continue. Had Frank been offered inpatient or residential treatment for alcohol detoxification, the following recommendation from NICE would have also applied: 'For people with alcohol dependence who are homeless, consider offering residential rehabilitation for a maximum of 3 months. Help the service user find stable accommodation before discharge'. Achieving a successful outcome in these cases and identifying appropriate residential accommodation after detoxification does, however, require significant multi-agency working between health services, mental health services and housing. This therefore leads to the following recommendation being made:

### **Recommendation 2**

- **The LSAB should seek to ask whether relevant housing providers have access to appropriate accommodation for supporting people with complex mental health needs like Frank, and specifically the needs of people who might require accommodation during/after admission for inpatient detoxification?**
- **If the process of this inquiry is to raise a concern regarding available resource, this issue should be brought to the attention of relevant commissioners.**

## **Effective Inter-agency working**

- 10.7. As stated, it is likely that delivery of Frank's care could have been improved through better inter agency working. Specific problems were firstly the fact that many agencies were not aware of the involvement of other agencies, and so could not coordinate care (and associated with this, the invitations to various multi-agency meetings did not always lead to the most useful people being involved), and secondly the fact that there did not seem to be a lead professional or agency coordinating care. The following recommendation is made:

### **Recommendation 3**

- **In complex clients with multiple health and social needs, the LSAB should seek to explore whether improvements can be made in the way in which agencies communicate their involvement (or at least the fact that they are involved) with other agencies.**
- **The LSAB should also review pathways for the identification of a lead professional or agency for complex clients who are known to multiple agencies.**
- **In practice, these recommendations will need discussion and liaison between and within a range of different agencies. The LSAB may be well placed to centrally coordinate discussions with senior staff in conducting these discussions. One practical suggestion for addressing these issues may be to set up a multi-agency working party who reports back to the LSAB.**



## Professional Curiosity

- 10.8. It is observed (8.17), and was reflected upon at the PLE, that practitioners had variously recorded Frank's place of birth as either Iran or Iraq. This is clearly a significant difference and whilst superficially unimportant, I have suggested this may reflect a potentially wider lack of professional curiosity on behalf of some agencies working with Frank, noting that Frank's 'story' was, at best, only partially known by professionals working with him. There are various potential reasons why professionals did not show this curiosity, including resource limitations (professionals feeling that they had a limited professional scope; professionals feeling they did not have time to ask more than the 'essential' questions); potential cultural unawareness or misplaced concerns about causing offence by asking; lack of belief of the importance of understanding wider contextual issues; beliefs that such issues were already considered by other agencies; language issues; as well as, of course, the impact of having to deal with more immediate health and welfare concerns. Unfortunately, these sorts of observations about practice are not uncommon.
- 10.9. It is difficult to develop a specific recommendation for the LSAB to 'improve' professional curiosity more widely, or quickly. Long term solutions which aim to release professional 'time to care', or potentially efforts to ensure the curriculum of professional training emphasises the importance of professional curiosity, may well be important components of an appropriate response. This therefore leads to the following recommendation:

### **Recommendation 4**

- **The LSAB should consider developing or supporting a long-term strategy for improving the 'professional curiosity' of clinical staff.**

## Safeguarding

- 10.10. There were relatively few safeguarding concerns raised, and certainly there were occasions of missed opportunities for safeguarding concerns to be raised. When safeguarding concerns were raised, these were unfortunately relatively quickly closed, with one safeguarding referral noting that Frank did not appear to have any care needs. This conclusion is particularly difficult to understand. Frank could have been offered an assessment under the Care Act (s.9(1)) and this may have led to identification of wider mental health needs and a need for formal referral. This leads to a specific recommendation:

### **Recommendation 5**

- **The LSAB should review the process by which the need for a s.9 Care Act assessment is raised through the safeguarding referral process. The LSAB may wish to audit the extent to which this occurs currently to establish if this is in line with expected population need. If only a small proportion of safeguarding referrals lead to a s.9 assessment, the LSAB should consider whether there is a need for increased resources or modifications to the safeguarding referral pathway to ensure this occurs.**
- **More broadly, the LSAB should continue to support work which aims to 'raise the profile' of the safeguarding referral process with agencies. Again, an audit may inform which agencies locally provide lower than expected rates of safeguarding referrals, and approaches for training or awareness raising may be targeted towards these agencies.**

## Learning for Specific Agencies

- 10.11. A number of potential learning points relate to specific agencies and are captured in the following recommendations:
- 10.12. Whilst Drug and Alcohol services noted the presence of clear safeguarding issues – formulated along the lines of self-neglect, it did not make a formal safeguarding referral. The reasons for this are not documented. It is unlikely that a formal referral would have meaningfully changed the outcome for Frank's case. However, this may be an important learning point for future cases. **Recommendation 6.1:** It is recommended that the LSAB ask Drug and Alcohol services to review its process for escalating safeguarding concerns, particularly in relation to self-neglect, and consider why a formal referral was not made in this case. This may involve further staff training or updating of policy guidance/processes. However this recommendation is made recognising this as an individual instance and with no evidence of there being any systemic failing in Drug and Alcohol services escalation of safeguarding concerns.
- 10.13. Frank was a frequent attender at A&E and clearly his behavioural presentation made it difficult for staff to work effectively with him. It is likely, however, that his behavioural presentation was related to his underlying PTSD and heightened anxiety within these situations. **Recommendation 6.2:** It is recommended that Local Hospital Trust review awareness/training for working with clients who present with PTSD and/or alcohol detoxification and associated anxiety.
- 10.14. Similarly, during the review process, it came to light that Local Hospital Trust do not have access to SystemOne – the clinical records system used by local GPs. This means that upon admission A&E need to contact the GP by phone to ascertain what medication a particular patient is on. Obviously, this is not often going to be possible, and therefore risks the provision of inappropriate or even harmful treatment that might be contraindicated by an alternative medication being prescribed. **Recommendation 6.3:** It is recommended that Local Hospital Trust review processes with a view to allowing A&E access to basic medical details held in GP records on presentation at A&E.
- 10.15. Finally, the point of transfer between housing agencies from District Council 2 to District Council 1 appears to be a point at which Frank's case no longer was actively managed by a housing provider. District Council 1 did not process the case at least partly because of non-returned paperwork (a medical form), but also because of a lack of ties to the area. This is not to suggest that established procedures were not followed, but it is reasonable to wonder whether, in hindsight, Frank's engagement could have been maintained at this point through a more active 'outreach' based approach. Paperwork and processes may well have proved an obstacle to engagement. **Recommendation 6.4:** District Council 1 should consider whether it would have been possible to have maintained active contact with Frank at this point given his wider health and mental health needs. District Council 1 may wish to consider whether an advocacy service could have been more actively involved in this process.

**Report written by:**

A handwritten signature in black ink, appearing to read 'Peter Beazley', written in a cursive style.

**Dr Peter Beazley BA LLM DClinPsy AFBPsS  
Consultant Clinical Psychologist**

## 11. Appendix 1 - Frank's Lived Experience Prior to 2016

- 11.1. Whilst some latter records record Frank's birthplace as Iraq, the balance of historical records, as well as official documents including the Coroner's Record of Inquest form, record that FRANK was born in Tehran, Iran, in 1962. We know nothing of his family situation at this time, their status in society, his education or his life experiences during his early years. It is believed that much of his family are still abroad, presumed in Iran, but it was noted at the practitioner learning event that a number of the family flew over for the funeral.
- 11.2. The records made available at the Practitioner Learning Event indicated that Frank served in the army from 1981-1983, i.e. in early adulthood. This would coincide with the 1980-1988 Iran-Iraq war. It is not known whether he was conscripted or signed up voluntarily. We have little information about his experiences in the army, or indeed with whom he fought. It is recorded that Frank spoke about fighting alongside a 'resistance' movement, perhaps suggesting he was sided against government forces (and potentially suggesting that this may have led to problems for him after the end of the war), but this is not clear. He also spoke about 'his men', perhaps suggesting that he had a rank or position of some seniority.
- 11.3. The records then report that Frank moved to the UK in 1994. His legal status and reasons for coming to the UK at this time are not recorded. Later records indicate that he held British Citizenship, but it is not known how he acquired this. In 1997, a letter published in the press acknowledges the receipt of a job application to work as a Graduate Assistant to Professor Stephen Hawking at the University of Cambridge. It does not indicate whether or not he was shortlisted.
- 11.4. In 2008, police records indicate that FRANK was convicted of drink driving and was disqualified. He also received police cautions for making off without paying (for petrol) and possession of Heroin and Cocaine in 2008. The records indicate these convictions either occurred in Herefordshire or Avon and Somerset. These records are important as they indicate that significant functional impairment in relation to alcohol use had been a longstanding feature of Frank's presentation – at least ten years prior to this death. They also suggest that Frank's use of substances was potentially not limited to alcohol, though the balance of information available suggests that alcohol most likely was the largest contributor to functional impairment.
- 11.5. The local press report that whilst in Bristol Frank had studied Aeronautical Engineering.  
There is also a 2009 newspaper article (from Bristol) recording that Frank was the victim of a physical assault, from the son of his partner at the time. The newspaper article indicates that Frank experienced a significant head injury, requiring 25 stitches in his scalp. The judge also noted to have taken into account 'an element of provocation' in passing sentence. Further details are unknown and there is no official record beyond the newspaper article available. It is noted that there is no record of this in his Essex medical records and no indication whether he was assessed for any cognitive or functional impact as a result of the head injury.
- 11.6. It seems that between 2008-2010 Frank was working in Essex at Stansted Airport. He is registered as a company director of ABC Aero Engineering (name changed) from November 2008. The company dissolved in July 2010. The company was registered to an address in the Dunmow area. Local press reports indicate that he was made redundant around this time, but full details are unknown. A record shared at the learning event, however, noted that Frank had been referred to CDAT from June 2009 until February 2010, again suggesting there had been long-standing functional

impairment associated with his alcohol use. The nature of input received from CDAT at this time is not clear.

- 11.7. A note from police records indicates that in 2012 Frank is known to the Metropolitan police for 'causing distress'. Further details are not provided.
- 11.8. Information shared at the practitioner learning event indicated that around 2012/13 Frank's father was diagnosed with cancer. It appears this event potentially coincided with the increase in antisocial behaviour that led to the need for more assertive input from the Housing Association, however it is not clear whether there was any causal connection, and it became clear during the learning event that antisocial behaviour and problematic alcohol use had been a long-standing element of Frank's presentation prior to this (in between periods of relative stability).
- 11.9. It was noted at the learning event that in 2014 there was an episode during which Frank had noted to have been on hunger strike. He had been noted to have spoken of his nephews visiting to celebrate the Persian New Year.
- 11.10. The description from the housing agency who provided Frank's house was that in the years prior to 2016, Frank was known to have dependency issues with alcohol, but he was generally well liked. Staff particularly noted his hospitality towards staff (for instance always offering chocolates). They noted that he had unusual sleeping arrangements; for instance being unable to sleep in his main bedroom. It was understood that this was because of flashbacks associated with PTSD. It appears that as his alcohol use increased, so did some elements of antisocial behaviour, which caused him to then be subject to some hostility from elements of the local community. The housing agency reported that they attempted to work closely with Frank for at least four years (i.e. since 2012), trying various methods to attempt to manage and reduce his presenting antisocial behaviour without success.
- 11.11. The nature of the antisocial behaviour can be seen through the police records. This indicates allegations of verbally abusive behaviour towards several other people in the local area, acts of antisocial behaviour such as repeated banging on central heating pipes, acts of criminal damage (e.g. kicking a neighbour's door, damaging parked cars) and some indication of physical violence including kicking one of his neighbours, and punching another on the face. On one occasion, when Frank was arrested for an offence of affray, he had in his possession a pair of nun chucks. In March 2016, a neighbour called the police after witnessing FRANK smash her car with a wrench. Frank was arrested, but found 'covered in blood, blood stains to his front door'. It appears that Frank told the ambulance crew who took him to hospital that he had been assaulted by the police.
- 11.12. Unsurprisingly, these behaviours had led to Frank receiving an injunction, which he then went on to breach. Ultimately, in April 2016 he served 21 days in custody at HMP Chelmsford. No records have been obtained to confirm this or summarise his presentation during this time.
- 11.13. A few weeks later, in May 2016 (after release from prison) Frank was noted to have been escorted to A&E by the police. The records indicate he was being transferred to a mental health unit by a paramedic and assaulted the paramedic. It was recorded that he had been on hunger strike for 16 days but was drinking alcohol. The specific concerns about mental health (beyond the hunger strike) are not clear and further circumstances about this episode are not recorded. Whilst at court dealing with the subsequent breach of injunction, Frank was then further arrested for verbally threatening behaviour towards his solicitor and other members of the solicitor's firm.

11.14. On the 21<sup>st</sup> June 2016, a possession hearing occurred in relation to Frank's tenancy. Possession is awarded to the housing authority. Notes from the housing authority indicate that 'Judge found Frank was not a credible witness, he refused to acknowledge any responsibility for his actions, denied he had an alcohol dependency (after earlier agreeing for a referral to alcohol services as part of these proceedings), disagreed with the psychiatric assessment to the contrary, and disagreed with his own legal defence'. A copy of the psychiatric assessment completed in relation to these proceedings has not been obtained.

### Abbreviations Used in this report:

CCG – Clinical Commissioning Group

LSAB – Local Adults Safeguarding Board

MCA – Mental Capacity Act (2005)

NICE – National Institute for Health and Clinical Excellence

PTSD – Post Traumatic Stress Disorder