Briefing Note

SAR Paul & SAR James

Liverpool Safeguarding Adults Board are today (31.07.24) publishing a thematic Safeguarding Adults Review (SAR) focussed on the deaths of two individuals, Paul and James.

Paul died on 16th April 2022, aged 39.

Paul was known to use substances, including alcohol and cannabis. Over time Paul experienced challenges with mobility and reported numbness in his lower body, seizures and on occasions, hallucinations. Members of the community and his family raised concerns to professionals regarding Paul's ability to care for himself and his extremely poor home conditions, despite this, professionals were unable to engage Paul in support.
Sadly, in April 2022, Paul was found by a neighbour deceased in his flat.

James died on 20th October 2021, age 56.

James had complex physical and mental health needs and was known to agencies, despite this, professionals struggled to engage him with support. James had a long history of mental health related illness and had been detained under the Mental Health Act 1983. In October 2021, whilst detained under section 3 of the Mental Health Act in a mental health hospital, James suffered a heart attack and was transferred to an acute hospital trust. James did not engage with the treatment and clinical management plan and was returned to the mental health hospital. However, on the morning of the 18th October 2021, he again complained of chest pain and was taken back to acute hospital where, despite emergency efforts to resuscitate him, he subsequently died on the 20th October 2021 following a cardiac arrest.

The SAR panel identified focused themes for analysis:

- Multi-Agency Risk Management
- Professional Understanding of Mental Health Act and Mental Capacity Act
- Duty of Care
- Court of Protection
- Dual Diagnosis pathways
- A person's lived experience
- Application of Professional curiosity
- Self-neglect / Hoarding
- Discharge planning / risk management / supervision
- Engagement with General Practice (GP)
- Family involvement in care planning
- Impact of the Covid pandemic on the care and support offer
- Missed opportunities

A key focus of the review was to identify areas for improved practice including any obstacles or barriers to achieving it, and to highlight areas of good practice.

The Board wishes to record their condolences to the families of both Paul and James.

The Liverpool Safeguarding Adults Board and its partners fully accept the report and its recommendations. The partnership is now working on addressing the recommendations with a multi-agency action plan, which is in place to drive improvements in how professionals work together to improve services offered to adults with the challenging needs identified in this review.

Duncan Dooley-Robinson

Independent Chair
Liverpool Safeguarding Adults Board

Please note pseudonym names have been selected to help to protect the identity of both individuals and their families.