Liverpool Safeguarding Adults Board

Safeguarding Adults Review

Paul and James

LIVERPOOL SAFEGUARDING ADULTS BOARD

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1. Introduction

1.1. This joint Safeguarding Adults Review was commissioned by Liverpool Safeguarding Adults Board following Safeguarding Adults Review referrals being submitted to Liverpool Safeguarding Adults Board by Liverpool City Council, Adult Social Care in relation to Safeguarding Adults Review Paul, and Mersey Care in relation to Safeguarding Adults Review James. Following screening of both cases, a decision was made to progress both cases as a thematic Safeguarding Adults Review on the grounds that the circumstances around both Paul and James met the statutory criteria in accordance with the Care Act 2014[1] and concerned similar matters of professional practice. Liverpool Safeguarding Adults Board appointed Allison Sandiford as lead reviewer. Allison is an independent safeguarding consultant with a legal background, who gained experience in safeguarding whilst working for a police service. Since 2019 Allison has conducted safeguarding adult's reviews and safeguarding practice reviews in both children's and adults safeguarding, and domestic homicide reviews. Allison does not have any links to Liverpool Safeguarding Adults Board or any of its partner agencies.

1.2. A Panel was established to oversee the review - membership of which is shown at Appendix A. The panel met on three occasions and the review incorporated two virtual practitioner learning events in which the practice around Paul and James was discussed with professionals from key agencies who had worked with them.

1.3. Liverpool Safeguarding Adults Board and the lead reviewer wish to express their sincere condolences to the family and friends of both Paul and James.

1.4. Paul was known to misuse alcohol[2] and to be a cannabis user. Over time, Paul reported developing numbness in his lower body, and he began to experience mobility challenges. He also reported suffering seizures and on occasion, 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, but professionals were unable to engage Paul in support. Sadly, in April 2022, Paul was found by a neighbour deceased in his flat.

1.5. James was known to agencies and had complex health needs. Despite this, professionals struggled to engage him with support. James had a long history of mental health related illness (specifically a diagnosis of schizophrenia) and had been detained under the Mental Health Act 1983. In October 2021, whilst detained under section 3[3] in a mental health hospital, James sustained an initial Myocardial Infarction and was taken to hospital. A few days later, having been non-compliant with treatment and clinical management, James was returned to the mental health hospital. However, on the morning of the 18th of October 2021, he again complained of chest pain and was taken back to hospital where, despite emergency efforts to resuscitate him, he subsequently died on the 20th of October 2021, following a cardiac arrest.

2. Terms of Reference

2.1. The primary focus of this review for Paul is on the period from April 2020 (when a male reported concerns for Paul and his home conditions), up to the 16th of April 2022 when Paul was sadly found deceased.

2.2. The primary focus of this review for James is on the period from February 2020 (when a Housing Officer submitted a safeguarding referral to Adult Social Care), up to the 20th of October 2021, when James suffered cardiac arrest from which he sadly died.

[1] The Care Act 2014 states that Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. This is a statutory responsibility.

[2] Paul had a diagnosis of alcohol related epilepsy.

[3] The Mental Health Act 1983 – section 3 is a legal provision that allows for a person to be admitted to hospital for treatment of a mental disorder.

Areas for consideration:

- Multi-Agency Risk Management
- Professional Understanding of the Mental Capacity Act / Executive Functioning / the Mental Health Act / Statutory Legislation and Duty of Care – including the Court of Protection
- Professional Understanding of Dual Diagnosis Pathways
- Explore any Missed Opportunities (including any professional neglect through active omission)
- Professional Application of Professional Curiosity.
- Self-neglect / Hoarding
- Discharge planning / risk management / supervision
- General Practice Management
- Inclusion of a family member in care planning
- Professional Understanding of a person's Lived Experience
- Did the Covid pandemic affect the care and support offer.

Parallel Processes

2.3. HM Coroner concluded the deaths of both gentlemen to be of natural causes.

2.4. Mersey Care NHS Foundation Trust subject the circumstances around James's death to a Serious Incident Investigation and a 72-hour review. Liverpool Hospital Trust completed a rapid review. A summary of the findings can be found at Appendix 2.

Limitations

2.5. There have been some limitations to the review. Not all invitees attended the practitioner's events. And critically,

- no representative from Adult Social Care attended the practitioner learning event for Paul as the Social Worker involved with Paul has since retired, and
- no practitioner present had ever met or worked directly with Paul.

2.6. The reviewer is grateful to the Adult Social Care Community Manager, Team Leader and Social Worker who agreed to a separate virtual meeting regarding the practice around Paul.

3. Brief Synopsis of Paul

3.1. In April 2020 a male reported (via 999) that Paul was experiencing chest pains. North West Ambulance Service proved unable to contact or gain entry to Paul and the response was stood down. The following day, Paul contacted 999. He admitted to attending ambulance staff that he drank at least two litres of cider daily and smoked cannabis, but he refused a safeguarding concern and would not attend hospital. A few days later, ambulance staff attended once more after a neighbour reported concern. Paul again declined support[4].

3.2. In August 2020 Paul was taken to the hospital Emergency Department after he was found unresponsive (intoxicated with alcohol and cocaine). Paul was unhappy at waking up in hospital and discharged himself against advice. Within a week an anonymous caller contacted Careline[5] reporting that Paul's flat was 'not fit for human habitation'. The caller reported that Paul was having mobility and balance issues and had been using his bath as a toilet[6]. The following day, Careline contacted Paul's GP and it was decided to request a police welfare check. However, because Paul's health had been deemed the prominent concern, police requested an ambulance

[4] Had an ambulance been called on 5 occasions within the same month, the High Intensity team would have been alerted and a multi-agency approach would have been invoked in attempt to address the callouts. 3 calls in a short period of time would not raise any alerts.

[5] Careline is a 24-7 contact centre for social care enquiries and referrals for children, and adults.

[6] Family members have told this review that Paul's toilet had been broken for years.

instead. The crew gained access to Paul, but he refused to travel to hospital and was deemed to have capacity to make this decision.

3.3. In September 2020, Paul's GP advised him to attend hospital after he had consulted the Practice regarding leg weakness. The following evening, having fallen at a shop, Paul was taken to hospital and admitted[7]. He was referred to in-house alcohol services and to the dietician (blood tests evidenced a vitamin deficiency), but he soon absconded hospital.

3.4. Later that day, Paul reported 'males attempting to enter his flat' to police. He told attending Officers that children were emerging from stairs in the lawn and then disappearing. The Triage Car[8] mental health practitioner attended[9] but Paul said he did not need support and that the hallucinations were a result of excess alcohol and Librium medication (given earlier in the day). The mental health practitioner did not consider there to be evidence of serious and enduring mental health and noted no cause for concern. Police Officers completed a Vulnerable Person Referral Form which included mention of the flat being in an extremely poor state, and dirty[10]. The form was forwarded to Careline and a few days later Paul's GP attempted telephone contact but Paul did not respond. Notably none of the information was shared with housing.

3.5. On the 11th of December 2020, Paul self-referred to Liverpool Community Alcohol Services.

3.6. On the 24th of December 2020, Paul's sister contacted Careline reporting that Paul was severely neglecting himself, drinking six litres of cider a day, living in squalor and in urgent need of a social care assessment[11]. Two days later, Paul's sister rang 111 with concerns. An ambulance attended and crew gained entry to Paul in his flat. North West Ambulance Service report that following this visit (on the 27th of December 2020) a safeguarding referral was submitted to Adult Social Care which included concerns about filthy home conditions cluttered with rubbish, and Paul's arrangements with a 'friend' who bought him cider in return for cannabis (software evidences that this concern was opened by the local authority on the 29th of December 2020.) Also on the 27th of December, Paul's sister emailed Careline detailing her concerns further. She described Paul as having significant weight-loss, the flat smelling disgusting, rubbish everywhere, and said that a neighbour, who had Paul's bank card, brought food and alcohol for Paul in return for Paul paying for cannabis. Two days later, Prevention and Early Intervention Services completed a telephone assessment with Paul and learned that Paul was experiencing numbness in his lower body, could hardly walk, shower, or change his clothes, was incontinent, couldn't clean his flat and could only eat soup.

3.7. Paul was allocated a Social Worker mid-January 2021, but engagement was not achieved, and his case was closed in March 2021 without having met him or been inside his property. In early January 2021, Paul had undertaken an initial telephone assessment with alcohol services and had subsequently participated in five further telephone appointments. This intervention ended in March 2021 - Paul had engaged with the calls but proved unable to reduce his alcohol intake.

3.8. Other than a small number of contacts with his GP Practice and housing, there was no further professional involvement with Paul from March 2021 until Paul was sadly found deceased in April 2022.

4. Brief Synopsis of James

4.1. In February 2020 staff undertaking a gas safety check at James's flat submitted a safeguarding referral to Careline to reporting James's poor home conditions and presentation. When asked, the Housing Officer told Careline that she was unsure as to whether James had mental capacity. At the time, James was open to the Community Mental Health Team and the information was shared with the Community Psychiatric Nurse and Consultant, who attempted a joint visit with housing but could not gain access.

[7] Paul now confessed to using spice as well as alcohol.

[8] Mersey Care runs three separate mental health triage cars in partnership with Merseyside Police, North West Ambulance Service and British Transport Police across Liverpool and Sefton. Each car contains Mersey Care registered mental health practitioners and representatives from North West Ambulance Service, Merseyside Police or British Transport Police.

[9] Paul did not allow the mental health practitioner entry.

[10] Paul told Officers that he did not suffer with his mental health.

[11] Careline tried to contact Paul's GP but was unsuccessful.

4.2. In May 2020 the Community Mental Health Team informed housing that they were going to visit James to complete a covid welfare check. The following week housing telephoned the Community Mental Health Team for an update and to discuss concerns. A message was left requesting a call back, but the following month housing were told by email that the Community Mental Health Team could not share personal confidential information about James without his consent – however, they had no concerns. Housing replied to the email reminding them of the concerns raised by the gas engineer back in February.

4.3. Starting from May 2021 a multitude of concerns were raised regarding James as follows:

Date	Concern	Response
18.5.2021	Neighbours reported to housing that James was acting strangely and being abusive.	Housing attempted telephone contact with James a number of times but there was no answer.
29.5.2021	A neighbour contacted the police reporting James being abusive. The neighbour was concerned for James's mental health.	Police got no reply from James's address. A Vulnerable Persons Referral Form was submitted. This was dealt with by a hate crime coordinator and filed as having no consent to share.
14.6.2021	A professional visiting a neighbour reported concerns regarding James's behaviours to the police.	Police attended twice but got no reply from James's address. A Vulnerable Persons Referral Form was shared with Careline who shared with the Community Mental Health Team and Social Work team leader.
2.7.2021	The electric company attempted to visit the property with a magistrates warrant but were unable to access the meters due to the excessive hoarding and kitchen waste.	The electric company contacted Careline detailing hoarding/James's poor state. The concern was shared with the Community Mental Health Team.
24.7.2021	Police received a report of James being aggressive within his neighbourhood and acting strangely.	Attending Officers were concerned for James and contacted the Street Car, who James denied entry. The Police Officer submitted a Vulnerable Persons Referral Form reporting James to be unkempt, unwashed, unshaven, with very dirty feet, and the home to be hoarded and filthy (excrement in the bathroom, rubbish in the kitchen, cigarette butts on the floor, dirty mattress). The form was shared with Careline who shared with the GP and the Community Mental Health Team and sent James a letter signposting relevant agencies.
30.7.2021	A neighbour reported to the police that James had knocked at their door and said he would kill them.	Police submitted a Vulnerable Persons Referral Form which was shared with Careline who shared with the Community Mental Health Team.
13.8.2021	Police received a report of James banging and shouting in the communal areas of the property, threatening to kill everyone.	James informed attending Officers that the call was malicious. The Street Car was consulted but said that in the past, James had refused to engage. The Officer completed a Vulnerable Persons Referral Form which was shared with Careline who shared it with the Community Mental Health Team.
17.8.2021	Following contact with James, housing became concerned and submitted a safeguarding concern to Careline.	Discussion with the neighbourhood team and the Approved Mental Health Practitioners Hub. It was noted premature for a Mental Health Act Assessment, but a referral was made to the Street Car. Police attended to reassure neighbours.

4.4. Later in August 2021, due to the concerns for James's mental health, the Community Mental Health Team obtained a magistrates warrant to force entry to James's flat and on the 26th of August 2021, following a Mental Health Act Assessment, James was detained under section 2[12] and admitted to the mental health hospital (Hospital 1). Subsequently, James was detained under section 3 to remain.

4.5. Whilst on the ward, James refused to attend reviews and declined medications. He was dispensed medication for treatment of his mental disorder covertly under the section 3.

4.6. On the 13th of October 2021, James complained of chest pain and in the early hours of the 14th of October, James was admitted to a different hospital (Hospital 2) where he proved non-compliant with care and was deemed to not have mental capacity to make decisions relating to his heart attack.

[12] Section 2 Mental Health Act 1983 is a legal framework for detaining someone in hospital for up to 28 days for an assessment and treatment of their mental health disorder.

4.7. On the 16th of October 2021 James was returned to hospital 1. It had been decided not to continue with cardiac intervention as placing a stent without compliance carried substantial risk as James was unlikely to comply with a long-term management treatment plan. Whilst back on this ward, James was abusive and threatening towards staff. He was concordant with aspirin but refused other medication.

4.8. On the 18th of October 2021 James was returned to hospital 2 with further chest pain but continued to refuse to be monitored or comply with medication. On the 20th of October 2021, James collapsed in cardiac arrest. Cardiopulmonary Resuscitation was administered by health professionals but sadly was not effective.

5. Family Contribution

5.1. Family engagement is an important part of the review process as family is best placed to contribute knowledge of a loved one to the review. The Liverpool Safeguarding Adults Board contacted family members of both Paul and James to explain the Safeguarding Adults Review process and invite them to make contact.

5.2. The reviewer is grateful to the sisters of Paul for their willingness to meet and to help others through their reflections. Their voices are woven into the body of this report.

5.3. Liverpool Safeguarding Adults Board did not receive a response from family members of James. The reviewer and the Board understand and respect any decision not to be part of this process.

6. Analysis

Following multi-agency discussions of Key Practice Episodes, the following themes were identified for practice and organisational learning:

Covid

6.1. In December 2019 a coronavirus emerged which was quickly labelled a pandemic. As the virus gained momentum, major disruption followed with measures being introduced in an attempt to lessen its effects. The United Kingdom saw the Prime Minister announcing its first lockdown on the 23rd of March 2020.

6.2. As a result, professionals had to rapidly adapt to new working conditions which included many face-to-face appointments being replaced with telephone and virtual appointments[13] and many workers leaving the office to work from home[14]. Whilst dealing with the confusion of new conditions, professionals worked hard to maintain service and continuity for their patients and service users, but no one could escape the emotional distraction that the pandemic introduced. Everyone (including professionals) was understandably concerned for their own safety, as well as the safety of those around them.

6.3. The first lockdown started to be lifted in May 2020, but in an attempt to contain the virus, there followed months of restrictions across England which at times affected further closure of non-essential retail and hospitality, and personal restrictions of movement. And, on the 6th of January 2021, a rising number of coronavirus cases saw national restrictions being reintroduced. It wasn't until the 8th of March 2021, that England began a phased exit out of lockdown, and the final step was delayed until the 19th of July 2021 to allow more people to receive their first dose of a coronavirus vaccine.

6.4. It is clear that over time, practices, and communications within the new working conditions became more effective and the ability of staff to adapt is praiseworthy, but this review must look at the resulting quality of care that was afforded to Paul and James when they needed it.

[13] In the absence of face-to-face work with both service users and colleagues, virtual communication platforms such as Zoom and Microsoft Teams started to be utilised. At first, different sectors used different virtual platforms which stilted inter-agency communications and not everyone had access to computer stations or all of the equipment that they needed. Those that did weren't always familiar with the communication tools and had to rapidly learn how to use them.

[14] Although there was a certain amount of relief at the safety and flexibility of working from home, staff had to quickly adapt their home living spaces to the needs of multiple family members working from home whilst simultaneously attending to their children's educational needs.

6.5. Professionals had already encountered problems engaging James with services prior to the start of the Covid pandemic, and whilst he remained open to Community Mental Health Services[15] and was a tenant subject to a housing provider[16], James was not seen by any professionals during the pandemic until May 2021 (when neighbours reported him to be acting strangely and abusively). Unsuccessful attempts had been made to see James in February 2020 (just prior to the first lockdown) after the housing provider had contacted Community Mental Health Services to report concerns. And in May 2020, the Community Practice Nurse and a Social Worker had attempted a Covid welfare check - but whilst there had been evidence of James being active at the address, he was not seen.

6.6. Paul was regularly brought to the attention of professionals throughout the Covid pandemic. Police Officers and ambulance staff attended him at his home address, and he was seen in hospital.

6.7. It is commendable that Paul's overall experience of the frontline police service, at a time when Officers and staff were frenetically coping with the pandemic, does not seem to have been adversely affected. Officers still attended his home address and spoke with him face-to-face. Similarly, despite Covid creating resource problems for the ambulance service and demand increasing to a point that outweighed available resources[17], an ambulance attended Paul's address on every request.

6.8. As is widely known, the pandemic put the NHS under extreme pressure. Emergency Departments in hospitals, whilst utilising agency staff to manage staff absences, saw an increase in the amount of people attending. Likely because people were struggling to visit their GP surgery. However, Paul was taken to hospital when in need and in agreement.

6.9. In December 2020, Paul's sister raised concerns for Paul to Careline. As a result, the Prevention and Early Intervention Services conducted a telephone assessment with Paul (assessment via telephone at this stage is usual practice). During the assessment, Paul disclosed health issues including numbness from the waist down, being unable to shower, unable to cook or digest food and not able to look after his home. Given the seriousness of Paul's situation, best practice could have seen an urgent home visit from a duty Social Worker being arranged – but it was not.

6.10. This review has been unable to ascertain for certain whether this decision was influenced by the Covid pandemic, but all involved acknowledged the risks associated with a home visit to Paul at this time and the unprecedented and often confusing guidance that managers in all agencies had to ingest and implement. At this time in December 2020, a new variant of the virus had been identified and was described in the media as spreading rapidly. And concerns had developed regarding how efficient the covid vaccination would be against this new variant. By this time many people (including professionals) had already lost loved ones to the virus and this new threat was very real. Professionals were understandable torn, wanting to do their job to their best ability, but fearful of transmitting the virus themselves or unknowingly transmitting the virus home to family members.

6.11. Whether Covid was to blame for a home visit and/or face-to-face communication not being undertaken or not, its omission resulted in professionals not recognising Paul's true circumstances, and his inability to meet his personal care needs. Consequently, the associated risks of significant harm as portrayed to Careline by his sister, became diluted.

6.12. Paul self-referred to Liverpool Community Alcohol Services in December 2020 and he was offered (and engaged with) six sessions (including an assessment). However due to the Covid pandemic all the sessions were completed by telephone, and it is clear that this work was affected by the loss of face-to-face communication. Paul's true vulnerabilities and needs were unseen in the absence of professionals seeing Paul's presentation or gaining entry to his address. Even though Alcohol Services had spoken with Adult Social Care on a couple of occasions, Liverpool Community Alcohol Services remained unaware of Paul's self-neglect and consequently noted on the 14th of January 2021 on their report to Paul's GP Practice that there were no safeguarding concerns *although this would be monitored in brief treatment interventions and acted upon in accordance with Mersey Care safeguarding policies and procedures*. This demonstrates how telephone contacts can mask a person's true

[15] Community Mental Health Services suspended non-essential visits.

[16] The housing provider (who wouldn't normally make non-statuary visits anyhow), continued to undertake welfare visits if issues for a tenant were raised. In addition, reassuringly, to support their tenants the housing provider undertook welfare telephone calls.

[17] North West Ambulance Services during Covid undertook a number of measures to increase staffing including the use of Patient Transport Services staff and the use of army personal to help alleviate the extreme pressure it faced.

circumstances. For example, had staff from Alcohol Services met with Paul, his inability to shower, wash his clothes and attend his personal care would have been evident. Professionals at the learning event noted that more professional curiosity within the telephone consultations may have helped to uncover Paul's struggles and identify his vulnerabilities but recognised that there are less prompts over the telephone to practice such respectful uncertainty and to stimulate professional curiosity. Over the telephone, professionals' ability to making safeguarding personal was forfeited.

Learning 1: Telephone communication made it hard to understand and recognise Paul's needs and the level of support required.

Question: How can partner agencies who are continuing to utilise telephone/remote consultation assure Liverpool Safeguarding Adults Board that robust procedures are in place to identify those who require a home visit?

6.13. The housing provider attempted contact with Paul during the Covid pandemic in response to complaints of Paul leaving rubbish in the communal area. Paul did not answer the door when the housing officer knocked, and no other agencies were notified. In 2021 Paul's sister raised concerns to housing which included Paul's inability to pay his bills, his alcohol use, poor mobility, and his neighbour doing his shopping in return for cannabis. It was good practice that, despite this being during a lockdown, a Tenancy Management Officer and Anti-Social Behaviour Officer attended Paul and gained access to him and the property to discuss the concerns. Sadly, Paul declined offers of detox and support with cleaning and said that the only support he consented to was with repairs.

6.14. Possibly the most significant issue regarding the pandemic was its personal effects upon both Paul and James. Paul told his family that he was very worried about catching Covid. And whilst the review recognises that only Paul is able to truly inform of his reasons for refusing to attend hospital and (on the occasions when he did attend) self-discharging, he had cited to some professionals that this decision was Covid related.

6.15. Regarding Paul's alcohol usage, the Covid lockdown saw an overall increase in alcohol consumption. In July 2021 Public Health England released a paper called 'Alcohol consumption and harm during the Covid 19 pandemic'[18]. The findings show an increase in the heightened risk level of alcohol consumption from 2020 to 2021. Whilst post 2021 the levels have returned to normal - suggesting that it was lockdown which saw this rise in alcohol consumption - from March 2020 to March 2021, there was an increase of 59% in men who reported to drink over 50 units a week.

6.16. Less is understood regarding how James felt about Covid, but notably it was towards the end of the pandemic, in May 2021, when neighbours reported that his behaviour had changed. A study published in January 2021[19] shows that people with schizophrenia spectrum disorders were expected to be at higher risk of acquiring Covid and of having a poorer outcome. Particularly people like James who had medical comorbidities and was a smoker. And whilst we are unable to confirm how worried James may have been about contracting Covid, it is important to recognise that stress can worsen the symptoms of schizophrenia or trigger new episodes.

Case Management

6.17. When Paul was referred to Careline in December 2020 by his sister and by North West Ambulance Services, his case could have been allocated for a section 42 safeguarding enquiry[20]. Instead, it was sent to a Neighbourhood Social Work Team for allocation of a Social Worker and case management.

6.18. This review has explored this decision with the Adult Social Care Community Manager, Team Leader and Social Worker who agreed to meet with the independent reviewer and has established that the decision was based upon Paul's positive engagement with the initial telephone assessment - the purpose of which is to gather information to decide whether the legal authority to act under section 42 had been satisfied. Paul's confirmation that he wanted support and was willing to engage with workers, reduced professional concern of either neglect

[18] Alcohol consumption and harm during the COVID-19 pandemic - GOV.UK (www.gov.uk)

[19] Implications of the COVID-19 pandemic for patients with schizophrenia spectrum disorders: narrative review | BJPsych Open | Cambridge Core

[20] The Care Act 2014, Section 42 (2) requires a local authority to make statutory enquiries, or cause others to do so, where it has reasonable cause to suspect that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect and as a result of those care and support needs is unable to protect him/herself against the abuse/neglect or the risk of it.

or abuse, negating the legal authority - as it was considered that Paul's circumstances could be managed through support work.

6.19. However, the initial decision to allocate Paul a Social Worker did not prevent his case ever being re-referred for section 42 enquiries and this could have been considered as an alternative to closing his case when engagement was not achieved. Had Paul been re-referred for section 42 assessment, his case would have then become subject to statutory guidance, and whilst timescales for completing enquiries aren't specified in the Act (and are to be negotiated with all relevant parties), it would have been expected that enquiries would have been completed within 28 days (unless there are exceptional circumstances).

6.20. Instead, the Social Worker concluded from third party information that Paul was no longer in need for Adult Social Care support and had chosen not to engage with support. This is discussed further in the next section of the report but raises concerns that mental capacity potentially may have complicated professional decision making.

6.21. Professionals spoke of Paul's right to not accept professional support. That is, make 'unwise decisions'. This is correct but an unwise decision regarding a Care Act Assessment under section 1(3) of the Care Act 2014 does not negate the local authorities' duties. Whilst section 1(3) of the Care Act 2014[21] is not dismissive of an individual's judgement and/or wishes and feelings, the word, 'unwise' does not appear and if an adult refuses an assessment of care and needs, it must still be carried out if the adult is experiencing, or is at risk of, abuse or neglect – including self-neglect. And it was known that Paul was, because in December 2020 Paul's sister had reported that:

- Paul had lost a significant amount of weight,
- had extremely poor mobility and had deteriorated cognitively,
- was unable to maintain home conditions,
- was drinking cider daily,
- was unable to leave his property, and
- was buying a neighbour £10 of cannabis daily in return for him going to the shops for alcohol and chips.

Much of this had also been confirmed by Paul himself during the telephone assessment.

6.22. If professionals, faced with having to consider closing a case due to 'non-engagement', deemed that Paul declining the Social Worker access did not meet the threshold for a section 42[22] enquiry, they could have instead convened a multi-agency meeting (whilst best practice would see such action being undertaken with Paul's consent, his consent could have been overridden with a risk of significant harm). At the very least, a multi-agency meeting would have ensured that Paul's information and circumstances had been shared and considered multi-agency, and multi-agency discussion been had (and recorded) about the likelihood of risk or neglect occurring, and the potential outcome of both intervening and not intervening.

6.23. James' mental health was managed by Community Mental Health Services but from around 2016 mental health services had failed to engage James in any meaningful therapeutic manner and he had not attended outpatient appointments or accepted treatment. Consequently, in June 2021, James was discharged from the Community Mental Health Team back to the care of his GP due to non-engagement. This decision was influenced by James's diagnosis of paranoid schizophrenia having been disputed by a locum consultant who said that James's presentation was more in line with an antisocial personality and the absence of a known relapse episode in more than a three year period ruled out schizophrenia and the requirement for antipsychotic treatment. The discharge was challenged by the Mental Health Social Worker and the GP, but without effect.

6.24. Best practice would have seen the GP Practice, upon becoming aware that the specialist team was no longer able to monitor and manage James effectively – convening a multi-agency meeting, particularly as it was only the following month when Careline shared concerns for James's poor presentation and living conditions.

6.25. It was good practice that on the 19th of August 2021, based upon the new concerns and continuing lack of engagement, the GP referred James to Careline to request assessment under the Mental Health Act.

[21] The main statutory framework which guides safeguarding adult practice.

[22] Under Section 42 of the Care Act 2014, local authorities have a duty to make, or cause to be made, enquiries in cases where they reasonably suspect that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect, and, as a result of those needs, is unable to protect themselves from this actual or risk of abuse and neglect.

6.26. In summary, the case management of both Paul and James was affected by professionals' inability to engage either of the individuals over a period of time. This is explored in the next section.

Hard to Reach Individuals and Multi-Agency Risk Management

6.27. Overall, professionals struggled to engage either Paul or James.

6.28. People have complex lives and consequently there is a wide range of potential reasons why it may be difficult to gain access to an adult for whom there are concerns. The individual may harbour a mistrust of authority, feel guilty or embarrassed by their circumstances, or fear being removed from their home. Attempts to engage a hard to reach individual should begin with discussion, encouragement, and the building of trust.

6.29. Little is known about James, but some professionals were aware that he was ex-military having served in the British Army's Parachute Regiment. As the military is a highly structured environment with distinct social norms, transitioning into civilian society can be challenging for ex-servicemen and women who have to adapt to the loss of the military's supportive framework. Adjustment to civilian life can result in "reverse culture shock" and identity conflict[23].

6.30. Veterans HQ Liverpool is a charity organisation (funded by NHS England) that provides information, advice, and support for ex-armed forces personal and reservists living in Liverpool and their families. Any professional can signpost or refer an individual to Veterans HQ, whether it is to offer them a safe and secure place to chat with other people who share their lived experiences or for something more such as housing support, help navigating the benefit system, addiction programmes[24], or mental health support.

6.31. It is recognised that had James been referred to Veteran HQ he could potentially have found it difficult to attend the establishment in person, but Veteran HQ will meet individuals in their homes or in the community and can advocate as required. It is also recognised that there is no assurance that Veteran HQ would have successfully engaged James but being approached by a service exclusively for ex-military can foster a sense of belonging. Because veterans share the common experience of military life and culture, individuals may feel more comfortable and less judged.

6.32. It was clear from professionals engaging with this review that more awareness of this service is needed to encourage professionals to utilise it.

Learning 2: The available support for ex-military is not widely known or understood by professionals.
Question: How can Liverpool Safeguarding Adults Board and its partner agencies work with Veteran HQ to ensure that all agencies and their staff are aware and understand how to refer an individual to its services?

6.33. Some insight into the potential obstacles services faced engaging Paul is gleamed from the Preventative and Early Intervention Services Assessment undertaken in December 2020 when Paul disclosed that he was embarrassed. There is no evidence of any professional exploring Paul's non-engagement within the context of any such embarrassment. To the contrary when Paul did not respond to professional contact, intervention appears to have withdrawn.

6.34. Where an adult like Paul has substantial difficulty in being involved, the local authority should consider arranging for an independent advocate to represent them for the purpose of facilitating their involvement[25]. For example, Paul may have potentially benefitted from an advocate who could have supported him with his benefits and his housing concerns (he disclosed that one of the reasons he was reluctant to allow people inside his address was fear of eviction if the housing provider recognised how poor his home conditions had become).

6.35. But, in James's scenario where professionals struggled to achieve engagement whilst he was in hospital under section 2, and later, section 3 of the Mental Health Act, an Independent Mental Health Advocate may have helped. An Independent Mental Health Advocate's role is to support people to understand their rights under the

[23] Ex-military personnel's experiences of loneliness and social isolation from discharge, through transition, to the present day | PLOS ONE
[24] Importantly Veteran HQ link with Tom Harrison House which is a specialist facility providing an addiction recovery programme exclusively to military veterans, reservists, serving personnel, and their families.
[25] Community advocacy refers to all advocacy that is not a legal entitlement.

Act and participate in decisions about their care and treatment. Every local authority has an obligation to ensure that there is an Independent Mental Health Advocate service in place.

6.36. This review has been informed that a referral was submitted for an Independent Mental Health Advocate for James on the 31st of August and again on the 5th of October 2021. Unfortunately, the review has been unable to determine the outcome of the proposed intervention from hospital records as the Independent Mental Health Advocate would have liaised directly with James - and the ward would not have been involved. Best practice would have seen any declination from James of advocacy being fed back to ward staff, but nothing is documented in case notes.

6.37. The N-compass advocacy service in Liverpool has been contacted during this review in an attempt to understand more about James and his response to advocacy but it was a previous advocacy provider who held the contract in 2021. N-compass do not have details for any contact with James and consequently this review has been unable to explore further.

6.38. However, regardless of whether previous engagement had been successful or not, an Independent Mental Health Advocate could have been further offered to James when on the 15th of September, James voiced concerns regarding decisions made by the Consultant about his depot medication. Instead, James was advised to approach the Patient Advice and Liaison Service but given that James had been assessed as lacking capacity to make decisions regarding his mental health care and treatment, it would have been more appropriate to reiterate the benefits to James of engagement with an Independent Mental Health Advocate.

6.39. Regarding James's mental capacity to make decisions, had it also been decided that James lacked capacity to decide whether he wanted the support of an Independent Mental Health Advocate, the hospital manager should have asked an Independent Mental Health Advocate to visit James and explain directly what help could be provided.

6.40. In addition, best practice would have seen James's community psychiatric nurse being contacted and asked to support engagement with James. The nurse had a well-established positive working relationship with James, and the Trusts engagement with the nurse may have been beneficial to support James in accepting physical health checks and treatment whilst on the ward.

6.41. Two days before he sadly passed away, James (because he did not have a close family member or person to support him) was offered an Independent Mental Capacity Advocate. Such an advocate would have been able to act on his behalf when he was found to lack capacity with certain decision-making aspects of his life but unfortunately the referral did not have time to progress. It has not been possible to establish from documentation whether there were any decisions that James was required to make earlier in his hospital admission, whereby he could have benefited from the offer of an Independent Mental Capacity Advocate sooner.

6.42. Some professionals[26] commendably tried to encourage Paul to engage with alcohol services but prior to December 2020, he had refused. Best practice would have seen professionals (upon refusal) considering other ways to engage Paul. In 2015 Alcohol Concern launched the Blue Light Project[27] which sought to support hard-to-reach drinkers, such as Paul, who fit into three criteria: alcohol dependent, a burden on public services and non-engagement with treatment. The Blue Light approach *challenges the belief that only drinkers who show clear motivation to change can be helped* and sets out tools and techniques that can be used with this group. At the heart of Blue Light is a manual[28], which sets out the key principles and contains a range of advice and tools for working with clients who are not in contact with services. Blue Light training supports professionals in applying the principles and tools, and helps local areas set up the multi-partner forums and protocols needed to embed the programme.

6.43. However, there will still be a small number of dependent drinkers who continue to place themselves at risk and pose an ongoing challenge to services. These drinkers are likely to require the more structured frameworks provided by legal powers[29]. Consequently, Alcohol Change UK worked with Professor Michael Preston-Shoot, a network of local authorities, and alcohol agencies across England and Wales, to develop a briefing: Safeguarding

[26] Ambulance staff and Police Officers

[27] The Blue Light Project | Alcohol Change UK

[28] The-Blue-Light-Manual.pdf

[29] In 2019, Alcohol Change UK reviewed 41 Safeguarding Adults Reviews to identify the role that alcohol played in the lives of these vulnerable people. The report, Learning from Tragedies, indicated that 25% of these serious safeguarding cases concerned dependent drinkers.

Vulnerable Dependent Drinkers[30]. The briefing aims to enable professionals in England and Wales to use legal frameworks to manage and protect vulnerable dependent drinkers. Its central focus is on the main legal powers which can protect vulnerable dependent drinkers, and how these can be used to best effect: the Care Act (England), the Social Services and Wellbeing Act (Wales), the Mental Capacity Act and the Mental Health Act. It also focuses on a handful of other relevant powers such as the 2014 Anti-social Behaviour Act and the Human Rights Act. Alongside the central focus on legislation, it emphasises the importance of having systems and processes in place that enable the powers to be used most effectively. In addition, it addresses the myths and misconceptions that hinder work with this group and challenges the idea that these vulnerable people are choosing to live chaotic lives. The briefing is of value to staff in all services who work with people who are at risk of alcohol-related harm.

6.44. Family is often a helpful aid for professionals struggling to engage an individual. Professionals attempting to engage Paul would have unquestionably benefitted from speaking with his sisters. They were able to offer the independent reviewer much insight into Paul in a very short time. Paul's sisters would have been able to furnish professionals with Paul's background, historic concerns, and could have helped them to understand his behaviours. In addition, they could have discussed what support the family had offered, and what support the family was currently able to offer. It may have been that Paul would not have consented to professionals speaking with family, but it is not a breach of confidentiality for a professional to listen to concerns about an individual[31], and Paul's sister had raised her own concerns for Paul to housing, Careline, the GP and to 111.

6.45. Paul's sister has told this review that the ambulance service did get back in touch with her after she had contacted 111. But she was disappointed to not hear from Careline after she had sent them emails outlining her concerns in December 2020. This review has learned that Careline did not contact her because their initial telephone assessment with Paul had been successful. Paul had not presented as withholding information and he had indicated (at that time) that he was willing to engage and would accept the support offered.

6.46. Paul's sister also informed the review that she had contacted Paul's GP regularly over the years but had found the Practice *to be unhelpful* using the lines of *due to confidentiality.* She described feeling as if no one was listening to her and said that she eventually stopped attempting contact as *she wasn't getting anywhere.*

6.47. Liverpool Community Alcohol Services informed the review that had they known Paul had sisters they would have attempted to involve family in Paul's care planning and updated them on progress. Paul had said he had no family and in the absence of information to the contrary, this remained unchallenged.

6.48. No family members were known to professionals working with James and no family member had reported concerns for James. It was only when he was in hospital that a cousin was found but the cousin had not had contact with James for several years. There is some confusion regarding whether James also had a sister.

6.49. As mentioned, engagement was initially achieved with Paul during the telephone communication with the Preventative and Early Intervention Services in December 2020, and Paul had agreed to further assessment and intervention. However, when a Social Worker began attempts to contact Paul, he did not respond, and engagement was not achieved. Though it is not documented how this was decided, Paul was deemed to have capacity to decline any further Social Care Assessment or intervention. This is rightly so, as people must be assumed to have capacity to make their own decisions and be given all practicable help to do so before anyone treats them as not being able to make their own decisions[32], but improved practice would have seen more professional curiosity used to explore the difficulties Paul may have been experiencing regarding responding to offers of support and how Paul was going to be able to improve his personal circumstances without professional intervention.

6.50. Being professionally curiosity is not always easy, but it is an essential component of safeguarding procedures, and its application is embedded in safeguarding adult policies and the Care Act 2014. It is expected within the British Association of Social Work Professional Capabilities Framework[33] that those entering social work education and the profession will: *"apply imagination, creatively and curiosity to practice"*. Consequently,

[30] How to use legal powers to safeguard highly vulnerable dependent drinkers | Alcohol Change UK

[31] Staff should make it clear to the person raising the concerns that it cannot be guaranteed that the patient/service user won't be told of the conversation.

[32] Paul's mental capacity is discussed in more detail later in the report.

[33] (PCF, 6) (BASW, 2018 p.26)

to support engagement questions needed to be asked, the answers to which could have supported professionals to understand Paul's situation better and to identify risk. The paper, *could curiosity save lives? An exploration into the value of using professional curiosity and partnership work in safeguarding adults under the Care Act 2014*[34], proposes possible ways to improve professional curiosity moving forward and to support professionals to develop professionally curious practice.

6.51. In the absence of a Social Worker achieving contact with Paul, Adult Social Care's professional curiosity could have started with a review of historic case notes, consultation with family or consultation with another service who had been successful with their contact with Paul. There is no evidence of case notes or family being consulted, but it was good practice that the Social Worker did contact the alcohol service professional. The Social Worker asked that the alcohol worker to pass messages to Paul and the aforementioned report to Paul's GP was shared. However, the report in the absence of further professional curiosity influenced a false impression of Paul's circumstances as it indicated good engagement from Paul and no safeguarding concerns. More curiosity into Paul's engagement would have identified that Paul's word was being taken at face value and that his narrative was untested.

6.52. Consequently, improved professional curiosity could have identified ongoing risks for Paul and resulted in his circumstances being considered against the *Liverpool Adult Services and Health guidance for practitioners: Failure to gain access to an adult believed to have needs for care and support who may be at risk of abuse or neglect* and escalated to managers.

6.53. Under this guidance, attention is brought to consideration of whether using the law to gain access is necessary, lawful, and justifiable, and of what powers could be most appropriate. Recourse to the courts and legal powers should be considered carefully - there is not always legal power to forcibly intervene and assess, but this option should always be explored in circumstances where engagement is not being achieved and significant risk of harm remains.

6.54. Good use of legal powers is exampled within the practice around James for whom there was reasonable cause to suspect was suffering from a mental disorder and was living alone and unable to care for himself. Under Section 135(1) of the Mental Health Act, where a person is believed to have a mental disorder, and there is suspected neglect or abuse: and upon application from an approved mental health professional, a magistrate's court has the power to allow the police to enter premises (using force if necessary and thought fit), to remove a person to a place of safety. James's Mental Health Social Worker, having become increasingly concerned for James and in recognition that it was necessary that he somehow be seen, sought such a warrant to allow a Mental Health Act Assessment to be executed.

6.55. Instead, Paul's case was closed to Adult Social Care without him having been seen.

6.56. Paul also struggled to engage with hospital treatment and on the two occasions that Paul was taken to hospital during the scoping period, he left prior to treatment concluding. In August 2020 he left against medical advice but documentation evidences that he had been given the relevant information and that he continued to discharge himself.

6.57. However, in September 2020 Paul left without warning or prior discussion. Whilst it is recognised that staff at the hospital would have been unaware of Paul's home circumstances, staff knew that Paul was vulnerable by means of his health, and whilst patients have a legal right to leave the hospital (unless they are detained under the Mental Health Act 1983, the Mental Capacity Act 2005, or Deprivation of Liberty Safeguards[35]), the Trust has a duty of care for the safety of its patients.

6.58. Under the *Standard Operating Procedure Absconding Patients*, a security alert could have been raised when it became clear that Paul was missing, and this would have included informing the police, next of kin and safeguarding team.

Learning 3: Hospital staff did not consider the full range of options available to them to protect Paul when he went missing from hospital.

[34] Accepted_Manuscript.pdf (uea.ac.uk)

[35] This is discussed in more detail later in the report.

Question 3: How can the NHS Foundation Trust Hospitals assure Liverpool Safeguarding Adults Board that they have ensured that all staff, including agency staff, understand the importance of the Standard Operating Procedure Absconding Patients, and know how and when to use it.

6.59. In line with standard practice, the hospital sent a discharge summary to Paul's GP surgery and a GP rang Paul a couple of days later - having also now received information outlining hallucinations that police reported Paul had experienced. Paul did not engage in the doctor's call and the doctor attempted further contact by telephone and text, advising Paul to contact the surgery if he required any medication. Paul did not respond but it is important to recognise that firstly, there is no guarantee that Paul received the messages/texts (he may have shared the phone with others, misplaced it or opened the messages whilst under the influence of alcohol and not remembered. Secondly, if Paul did receive the messages, it is possible that he may not have had the means to contact the surgery if he did not have any credit on his phone.

6.60. The hospital discharge letter did not suggest any 'urgent' follow up was required by the GP Practice and there was no action documented for the GP. But at the very least, in such situations, could a note be added to the summary which alerts the GP to the patient leaving the department in a vulnerable state prior to treatment, and highlight the concerns. This could then trigger (or action) the GP to make more urgent 'direct' contact than telephone calls (which proved ineffective). Whilst it is recognised that GP home visits are now used for end-of-life care or genuinely housebound patients only, a more direct method of contact is necessary when there are increasing concerns. Could in the event of a vulnerable patient not responding to a GP, a home visit be considered by a practice nurse or paramedic? Instead, in the event of Paul not responding to the GP, no further action was taken by any agency.

6.61. Professionals also struggled to engage James when he was in hospital but because he was being detained under the Mental Health Act, this practice is considered further later in the report.

6.62. In summary, in the event of any service continually being unable to engage an individual, the question that professionals should be asking themselves is, *what more can I do to safeguard this person?*

Learning 4: There were missed opportunities to share information, escalate concerns and develop action plans with other agencies when it was recognised that professionals were failing to be effective in the engagement of the person and in the management of risk.

6.63. This learning has now been addressed with the introduction of Liverpool Safeguarding Adults Board's Multi-Agency Risk Assessment Process in October 2022. This guidance is to be used *where there is concern that an individual's lifestyle or behaviour is likely to result in serious harm, or even death and single agency involvement has failed to be effective in the management of risk.* Deployment of the process (had it been available within the scoping period of James and Paul) would have resulted in a Multi-Agency Risk Assessment meeting[36] being convened and a Risk Management Plan being completed. Crucially in addition to all agencies being made aware of James's and Paul's situations, the ensuing Risk Management Plan would have identified a Key Worker who would have retained overall responsibility for coordinating the plan and the review meetings would have been scheduled.

6.64. In addition, the issue around missed opportunities to convene multi-agency meetings has been brought to the attention of Liverpool Safeguarding Adults Board in a recent Safeguarding Adult Review - Hazel[37], which has recommended that the Board consider reviewing available guidance about multi-agency risk management meetings and conducting a multi-agency audit to determine whether such meetings are being convened and used effectively.

Question 4: How can Liverpool Safeguarding Adults Board audit the effectiveness of the Multi-Agency Risk Assessment Process.

[36] Any staff from any agency can convene a Multi-Agency Risk Management Meeting

[37] Self-Neglect: SAR Hazel (liverpoolsab.org)

Professional Ability to Support Paul and James in their Homes.

6.65. Both Paul and James experienced self-neglect and hoarding. Their properties were described as having rooms that had become unfit for purpose, that were dirty, and cluttered with rubbish. Paul's sister has described how Paul was often without electricity, hadn't ever had gas and how his toilet had been broken for many years. He typically kept items that no longer worked and over time, some of his neighbours would leave their broken items with him too.

6.66. Some hoarders can remain well-presented to the rest of the world but during the scoping periods of this review both Paul and James presented as unable to meet their own basic self-care needs and this resulted in poor hygiene and dishevelled presentation.

6.67. Police Vulnerable Persons Referrals and the concerns reported to Careline detailed personal self-neglect and squalid home conditions but sadly this wasn't addressed– instead the concerns were directed to other agencies to address issues concerning physical health, substance misuse and mental health. None of which (agency) proved able to effectively engage either gentleman in support.

6.68. In January 2021 housing became aware of Paul's poor home conditions and during a visit at the end of the month offered support with cleaning (and alcohol detox). Paul declined the support but agreed to locks being repaired, curtains being supplied, and repairs being undertaken on the sink and toilet. The repairs are detailed as being completed in March and April and curtains being delivered at the end of April. There are notes on the case file which state that a Housing Officer would carry out further visits to the property in April and June 2021 but there is nothing to indicate whether these visits were attempted or successful. There is also nothing to evidence whether any of the information regarding Paul and his home conditions was shared with other agencies. The case was closed to housing in September 2021.

6.69. The *Liverpool Safeguarding Adults Multi-Agency Hoarding Protocol* notes that when services are unable to engage an adult (with capacity) who hoards and is at risk of harm, professionals should not automatically accept the decline of support as an unwise decision. It advises that contact should be maintained to build up trust, and if faced with constant refusal, consideration should be had to calling a safeguarding strategy meeting. The purpose of which is to assess the risk to the adult, decide if any further action is required, establish roles and responsibilities, decide which agency should take the lead and develop safeguard plans.

6.70. In addition, the protocol advises that *if it is deemed that the person has capacity and does not have a mental disorder that requires assessment or treatment and the adult continues to refuse services, the practitioner should complete a risk assessment and agree who is best placed to monitor the individual and periodically offer support for an agreed period of time. The case must not be closed without the approval of the manager and all information must be recorded in the adult's case notes.*

6.71. This protocol was not followed when Adult Social Care received the safeguarding concerns from Paul's sister and North West Ambulance Service in December 2020 - no strategy meeting convened, and the case was closed in March 2021. And, as detailed earlier in the report, regarding the self-neglect, the *Liverpool Adult Services and Health guidance for practitioners: Failure to gain access to an adult believed to have needs for care and support who may be at risk of abuse or neglect* was not followed either.

6.72. This review acknowledges the complexity of self-neglect and hoarding. Differentiation of how the conditions present is highlighted when we recall that although it is common for individuals experiencing the conditions to have entrenched beliefs regarding their behaviours, Paul sometimes acknowledged that he needed support and requested help (for example, when he engaged with the Preventative and Early Intervention Assessment). In contrast, James did not acknowledge any problems, but his circumstances differed from Pauls because James was known to live with a mental health disorder and there was legal power to forcibly intervene and assess.

6.73. Clearly all cases must be managed on a case-by-case basis.

Learning 5: Self-neglect and/or hoarding should always be addressed irrespective of how the person has come to neglect themselves i.e., alcohol misuse, mental health, etc.

The issues around self-neglect has recently been highlighted to Liverpool Safeguarding Adults Board within the Safeguarding Adults Review Hazel. The Board should consider the action plan produced in response to Hazel against the content and learning within this report.

Professional Understanding of and Response to Dual Diagnosis

6.74. Dual diagnosis is a term that means someone has a mental health disorder and a substance use disorder at the same time.

6.75. James lived with a mental health disorder but there was no known substance misuse.

6.76. Paul was struggling with alcohol misuse, but mental health problems were not determined by professionals who came into contact with him.

6.77. Members of Paul's family strongly believe that Paul did suffer with his mental health. His sisters informed this review of biological members of his family living with schizophrenia and there is ample research[38] that shows that schizophrenia is closely linked to a person's genetics. Historically[39], one of Paul's sisters had requested a Mental Health Act Assessment. Notably when historic records have been consulted, this is recorded as a request for a mental health assessment - highlighting the importance and need for professionals to clarify the concerns and details at the point of request. However, neither a Mental Health Act assessment nor a mental health assessment was completed. Instead, a GP appointment was offered to Paul. Had there been professional concerns around Paul's mental health, his GP Practice could have made a referral to secondary mental health services but there was no guarantee that Paul would attend any GP appointment offered in the first instance.

Learning 6: There was a missed historic opportunity to support Paul. And the missed opportunity effected the family to question their trust in professional intervention/support.

Question: How can Liverpool Safeguarding Adult Board explore whether professionals are effectively exploring concerns raised by family members regarding an individual's mental health, and if there is current concern, identify what steps can be taken to address it?

6.78. Within the scoping period of this review Paul reported (via alcohol services) that his mental health was stable. And when signs of mental health (hallucinations) did surface, they were deemed to be alcohol related (by himself and professionals present). It was good practice that despite this, Police Officers completed a Vulnerable Persons Referral Form which highlighted a mental health concern and detailed the hallucinations. As previously mentioned, this information was shared by Careline with Paul's GP, but because it was deemed an alcohol issue for which Paul declined support, no further action was taken.

6.79. Clearly, identification of dual diagnosis can be hindered when a person presents with acute intoxication, but professionals at the learning events for this review recognised that rather than consider an individual's multiple support needs as individual needs, it is necessary to think of them as whole needs and of the individuals having *complex lives*.

6.80. Unfortunately, services were not set up to address such complex needs or to encourage Paul and James' engagement. Whilst professionals were able to respond to immediate crisis, they struggled to engage either James or Paul with any follow-up services, and as such both individuals needs remained unmet. A dedicated and specialist Multi-Disciplinary Team would have enabled services to provide more effective pathways.

Learning 7: Professionals find it difficult to engage individuals who have 'complex lives' with long-term support difficult.

6.81. This review is assured that this learning is now addressed with the introduction of Liverpool Safeguarding Adults Board's Multi-Agency Risk Assessment Process whose guidance is to be followed *where there is concern that an individual's lifestyle or behaviour is likely to result in serious harm, or even death and single agency involvement has failed to be effective in the management of risk.*

[38] Schizophrenia | healthdirect

[39] In 2015

6.82. In addition, there is now an 'Integrated Care Team Multi-Disciplinary meeting for people living with complex lives' protocol. Complex lives is a term used when an individual has an overlap of a particular set of difficulties and behaviours which include either a physical health condition or a mental health condition with either homelessness, substance misuse, offending behaviour, high intensity user of hospital Emergency Departments, history of being a looked after child and/or domestic abuse. Both Paul and James could fit this description.

Professional and Public Understanding of and Response to Alcohol Misuse

6.83. However uncomfortable, the question must be asked whether professionals (outside of substance services) had enough understanding of alcohol addiction in order to support Paul. After all, the general public and media still sometimes refer to alcohol misuse as a lifestyle choice[40]. This is stigmatising and unhelpful and people who are alcohol dependent are consequently sometimes victims of discrimination, even when seeking help.

6.84. In December 2020 Adult Social Care gained a good insight into Paul's needs as a whole (not just his alcohol misuse) from his sister's emails and from Paul's telephone assessment with Preventative and Early Intervention Services. When Adult Social Care closed Paul's case in March 2021, it was known that Paul was engaging with alcohol services (though he had refused an inpatient detox placement and counselling) but Paul's other needs remained unmet. Later in the same month, Paul was discharged from alcohol services. The Social Worker wasn't informed because alcohol services knew that the case had been closed.

6.85. Consequently, Paul was left without any long-term support plan despite having:

- multiple health problems,
- alcohol addiction,
- extremely poor home conditions,
- being unable to meet his own self-care needs, and
- the person who he was reliant upon the most for food etc being a substance abuser and suspected to be financially exploiting him.

None of these concerns had been effectively addressed. Instead, the fact that support had been offered for the alcohol addiction was deemed adequate. But actually, Paul needed a multi-agency response to respond to all of his needs as a whole as per the complex lives approach outlined in the previous section of this report. Only supporting Paul to address the alcohol misuse was not enough. Why wasn't deeper analysis of Paul's self-neglect and vulnerability achieved? In the presence of alcohol, were the self-neglect and poor home conditions perceived as a lifestyle choice?

6.86. Paul's circumstances are echoed in the Alcohol Change UK report, learning from tragedies[41] which analysed 11 published Safeguarding Adult Reviews in which alcohol was identified as being a significant factor in the person's life and/or death. The overarching finding was that most of the adults, like Paul, had multiple complex needs in addition to alcohol misuse, including mental health problems, chronic physical health conditions, neurological conditions caused by alcohol, self-neglect, exploitation by others, unfit living conditions, and experiences of a past traumatic event. In almost all cases, support services failed to cope with that complexity.

6.87. Interestingly, four of the Safeguarding Adult Reviews involved men who had become unemployed, lived alone and lost contact with their families. The cause of death in these cases was related to self-neglect and refusal of care from services. The report highlights some key themes that can inform improved future practice, such as better multi-agency working, stronger risk assessments, and improved understanding and training for practitioners to help them better identify and support, in a non-stigmatising way, vulnerable people who are experiencing alcohol harm.

[40] For example, the NHS England Chief Executive was quoted to say, *"When the health service is pulling out all the stops to care for sick and vulnerable patients who rightly and genuinely need our support, it's frankly selfish when ambulance paramedics and A&E nurses have to be diverted to looking after revellers who have overindulged and who just need somewhere to safely to sleep it off."* These comments were made in respect of party goers drinking too much over a festive period, but they show an overall lack of understanding of alcohol misuse.

[41] ACUK_SafeguardingAdultReviews_A4Report_July2019_36pp_WEB-July-2019.pdf

6.88. Sadly, due to the professionals who worked directly with Paul not being able to attend the learning event, the review has been unable to explore this further.

Learning 8: The learning objective of Safeguarding Adult Reviews is hindered if key frontline practitioners do not engage with the process and/or their voices are not heard.

Question: How can partner agencies assure the Liverpool Safeguarding Adults Board that their practitioners understand the Safeguarding Adult Review process and its importance? And what alternative, timely ways could the Liverpool Safeguarding Adults Board consider in order to capture the voice of the frontline practitioners?

6.89. Professionals at the learning event discussed how people encountering individuals who misuse alcohol could benefit from a better understanding of alcohol withdrawal. Withdrawal from alcohol is complex and care planning is not straight forward. People who are clinically alcohol dependent can experience fits, shaking hands, sweating, seeing things that are not real, depression, anxiety, or have difficulty sleeping if they suddenly, completely stop drinking. At worse, they can die.

6.90. In September 2020, Police Officers attended Paul who had reported seeing children in his garden coming out of stairs in the lawn. Officers formed the opinion that Paul was hallucinating and suffering with his mental health (aggravated by excessive alcohol consumption). However, this was the same day that Paul had absconded from hospital, where he had been for around 18 hours without alcohol. Alcohol withdrawal can begin within hours of discontinuing drinking, and it is possible that Paul's hallucinations were linked to withdrawal.

6.91. Visual hallucinations are a symptom of delirium tremens which is one of the most severe manifestations of alcohol withdrawal. It is a medical emergency, ideally requiring inpatient care to allow medical professionals to offer medication and monitoring, that can be fatal if left untreated. Officers clearly considered taking Paul to hospital but interestingly, whilst the Vulnerable Persons Referral Form completed on this occasion noted that Paul wanted to remain at home, there is no mention of his capacity to make this decision. This capacity is discussed further later in the report.

6.92. In summary, consideration of Paul's circumstances evidences a need for more practical support for professionals to help them to

- recognise and understand the comorbidity of alcohol with for example, self-neglect, exploitation, abuse, and mental capacity,
- understand the importance of not severing contact with such an individual based upon their inability to engage with services,
- know when to seek additional advice and support (potentially from legal services, senior managers and/or safeguarding/Mental Capacity Act specialists), and
- appreciate the need for a multi-agency approach.

Learning 9: There needed a multi-agency approach to achieve a clear understanding of Paul's needs as a whole – not just in relation to his alcohol misuse.

Question: How can key agencies assure Liverpool Safeguarding Adults Board that their practitioners are able to access training to improve their understanding of alcohol dependency and awareness of addiction and associated risks, and know where to refer a person to when a person's needs are not being met?

Professional Understanding of and Response to Exploitation/Mate Crime

6.93. Whilst there is nothing to suggest that James was subject to any exploitation, this review has heard from Paul's sister that a neighbour was using Paul's bank card to purchase Paul food and alcohol in return for Paul buying him cannabis. Some professionals became aware of this indication of potential exploitation in December 2020 when Paul's sister included the detail in her concern to Careline and told ambulance staff, and in January 2021 when she informed housing. Yet no enquiries were made into the matter until after Paul had died.

6.94. It is recognised that because Paul provided the neighbour with his bank card and personal identification number, and because professionals deemed Paul to have the mental capacity to make his own decisions, there would have been insufficient evidence to pursue any criminal prosecution regarding money having been taken

from his account. But, whilst the criminal threshold had not been met regarding financial abuse or exploitation of Paul, all organisations have a duty to apply safeguarding duties.

6.95. Under Section 42 of the Care Act 2014, there is a legal duty to make enquiries about the safeguarding concerns because Paul; had needs for care and support, was at risk of 'abuse[42]' and, because of his care and support needs, was unable to protect himself from the risk of abuse. Yet there is no evidence of these enquiries having been made and there is no evidence of any consideration of Paul's capacity to manage his financial affairs being had.

6.96. Paul did not recognise himself as a victim of exploitation and he told his sister that he considered the person with his bank card to be his friend. However, even had he not considered the person a 'friend', it is easy to understand how potentially hard it may have been for Paul to disclose his situation. Particularly because according to neighbours, Paul was potentially being threatened by, or intimidated by, the individuals around him and was at risk of physical assault, as well as financial abuse. Neighbours reported arguments between Paul and 'friends' to housing in June 2021. And in April 2022, a neighbour raised concerns for Paul to housing describing him as 'vulnerable' and reporting that another individual living in the building had 'latched' onto Paul and had stolen his phone. There is nothing to evidence that these concerns were ever explored or shared multi-agency before Paul sadly died.

6.97. Individuals such as Paul particularly need robust safeguarding from exploitation as:

- their dependency upon, and the costs of their substance misuse (including alcohol) puts them at risk of exploitation, and
- this risk is coupled with the physiological effects of drugs and alcohol upon the body which can impact on people's decision-making abilities and memory - reducing a person's ability to recognise that they are in an abusive or exploitative situation, defend and protect themselves, or remember that they have been abused or exploited.

6.98. This review would also respectfully ask, in the absence of safeguarding enquiries being made, how could professionals be confident that the same individual who was using Paul's bank card wasn't also doing the same to other vulnerable members of the local community. Could more focus and curiosity have been on him. Could the situation have been brought to the attention of Local Policing. Maintaining contact and presence may have deterred further exploitation.

Learning 10: Professionals must be alert to signs of exploitation/mate crime and ensure that policy and procedures reflect the risk for adults at risk.

Question: How can partner agencies assure Liverpool Safeguarding Adults Board that awareness is being raised around the potential mate crime/exploitation of adults at risk, and of the wider public interest issues that arise when concerns around mate crime/exploitation/financial abuse originate (even when the criminal threshold for prosecution is not reached)?

Professional Understanding of and Response to Mental Health

6.99. James was assessed under the Mental Health Act and detained in hospital (Hospital 1), initially under section 2 but subsequently under section 3. On the 14th of October 2021 James was transferred to a different hospital (Hospital 2) to receive treatment for a Myocardial Infarction.

6.100. On the 16th of October 2021, James was returned to hospital 1 - he was presenting as medically stable but was refusing treatment, and because it had been longer than 72 hours since the onset of James's symptoms, an angiogram was no longer deemed to be in James's Best Interest. However, this was a missed opportunity to

[42] ***Section 42(3) of the Care Act 2014 in England defines 'abuse' as including financial abuse, which covers:***

- ***Having money or other property stolen,***
- ***Being defrauded,***
- ***Being put under pressure in relation to money or other property: and***
- ***Having money or other property misused.***

convene a Best Interest meeting to discuss more of James's options going forward and a management plan for his ongoing care and treatment.

6.101. On the 18th of October 2021 James was still experiencing chest pain. He was deemed to not have capacity to refuse examination and treatment, and a referral was made for both an Independent Mental Capacity Advocate and an Independent Mental Health Advocate. In subsequent discussion with the on-call medical registrar at hospital 2, it was agreed to be in James's Best Interest to sedate him to undertake tests. James was transferred back to hospital 2 for these to take place. Following the tests, a Best Interest meeting was held (on the 19th of October 2021). This meeting appears to have been missing key professionals, namely representatives from Hospital 1 and James's community mental health care coordinator. And potentially because not all the necessary representatives were present, the subsequent decision to discharge James back to hospital 1 was later challenged and met with concern regarding the lack of a management plan. It was subsequently agreed that a further Best Interest meeting would be called to fully discuss James's management and that legal representatives would be invited (sadly James sustained a cardiac arrest and died before this meeting could take place).

Learning 11: Best Interest meetings could have been convened in a timelier manner and would have proven more effective with better representation.

Question: How can partner agencies assure Liverpool Safeguarding Adults Board that their practitioners understand Best Interest meetings, and that Best Interest meetings are being convened in a timely and effective manner with the correct representation?

6.102. The review has been unable to ascertain for certain whether Section 17 leave[43] was invoked when James was transferred to hospital 2, or whether it was decided that James would remain subject to the Section 3 and a member of staff from the mental health hospital would remain with him at all times. Both documentation and practitioner views differ.

6.103. However, an application for Deprivation of Liberty was submitted on the 15th of October 2021 requesting authorisation for the 21st of October 2021 to allow tests involving physical restraints to be undertaken. This would suggest that James was no longer subject to Section 3 as the Mental Health Act has primacy over the Mental Capacity Act[44].

6.104. Unfortunately, it is not clear from James's case notes how the decision to apply for Deprivation of Liberty arose (refer to learning 11 – page 22)

6.105. Documentation evidence that James's capacity was kept under consideration whilst he was an inpatient at both hospitals 1 and 2. James was mostly deemed to lack capacity to make the decisions under review (around his refusal of treatment and medication), due to underlying mental illness, however some decisions appear to have been missed, for example, around his personal hygiene.

6.106. In addition, there are on occasion conflicting decisions. For example, though the review recognises that capacity is time and decision specific, it is confusing to see that on the 13th of October when James reported chest pains 30 minutes post his depot but refused any physical health checks, it is documented that James had capacity; and no formal capacity assessment had been completed.

6.107. Because James was under Section 3 of the Mental Health Act and his capacity was deemed to be impaired by mental disorder, consideration could have been had to utilising Section 63 Mental Health Act which can be used to treat physical disorders where they are believed to contribute towards or be symptomatic of a mental health problem. Research[45] has shown that schizophrenia is associated with heart changes, and that these changes could lead to an increase in the risk of heart disease and death in this group. This section of the Mental Health Act was brought to clinicians' attention but there is no record of its consideration or rationale.

6.108. Capacity is a legal concept and particularly given the serious consequences of many of James's decision it was crucial that robust assessment and documentation took place. Unfortunately, it is not always clear from

[43] Section 17 of the Mental Health Act 1983 allows patients who are detained under certain sections of the Act to be granted leave of absence from the hospital.

[44] GJ v The Foundation Trust [2009] EWHC 2972 (Fam)

[45] Physically healthy people with schizophrenia show heart changes that increase the risk of heart disease « Psychology & Psychiatry# « Cambridge Core Blog

James's case notes how his capacity has been assessed and how the consequence of his decisions have been explained to him (refer to learning 11 – page 22).

6.109. This review has been informed that Bi-Monthly Health Provider Collaboration meetings take place to develop Mental Capacity Act practice, and that these meetings involve both the Acute Trust and Mersey Care. This review would recommend that learning from James's case is shared within this meeting.

6.110. Paul's mental capacity was a vital element within his safety planning as with capacity, he was deemed able to make his own decisions regarding care and support. Under the Mental Capacity Act 2005, Paul had to be presumed to have capacity unless proved otherwise. Therefore, considering Paul's capacity rightly involved professionals asking themselves whether there was any reason to doubt his capacity in the first instance. Though the rationale for assuming Paul's capacity is not documented (and this review therefore remains unclear as to how Paul's capacity was fully considered) no professional documented doubting Paul's capacity. However, under recent proposed changes[46] to the Mental Capacity Act Code of Practice, which expand upon how to apply the statutory principle; 'A person must be assumed to have capacity unless it is established that he lacks capacity', the draft code states that, *assuming capacity should not be used as a reason for not assessing capacity in relation to a decision*. And

- *there should always be a proper assessment where there are doubts about a person's capacity to make a decision.*
- *the onus is on the person intending to carry out the intervention to have properly established that capacity is really lacking in the individual concerned.*

6.111. Consequently, the absence of a reason to not presume capacity should not have automatically concluded that assessment was not necessary. Instead of assuming capacity, best practice would have seen more professional curiosity from those attempting to support Paul. Professionals could have afforded Paul's capacity further critical reflection, and ruminated on how, given his presentation, and home conditions, they could be sure of their assumption of his ability to make decisions about how he managed, for example, his health, his home, his finances and importantly his decision to not attend hospital and/or to discharge himself.

6.112. Further critical reflection of Paul's capacity to engage with services may also have recognised that Paul appeared to have had the ability to understand the consequences of a decision but lacked the performative ability to execute the choice. For example, in December 2020 whilst on the telephone with the Preventative and Early Intervention Service, he agreed to a Social Care Assessment and Social Care support. However, he subsequently did not respond to phone calls or letters. This behaviour could have prompted consideration of decisional and executive functioning and capacity.

6.113. Executive functioning is a set of mental skills that helps a person to get things done. These skills are controlled by an area of the brain called the frontal lobe. When executive functioning isn't working as it should, a person's behaviour is less controlled, and they are less focussed. Executive functioning can be divided into two groups: organisation (collecting information and arranging it for assessment) and regulation (changing behaviour response in accordance with the environment). For example, in Paul's case, when he was attempting to reduce his alcohol intake in January 2021, and he thought about, or saw a drink of alcohol and found it tempting, he needed the organisational part of his executive functioning to interrupt and tell him that drinking the alcohol conflicted with his goal of reduction.

6.114. Upon recognising that Paul was repeatedly struggling to execute actions, professionals working with him could have suspected problems with his executive functioning which - whilst not evidence of a lack of capacity, could have affected Paul's mental capacity.

6.115. The 2011 Social Care Institute for Excellence paper *Self-neglect and adult safeguarding: findings from research*[47] highlighted executive capacity and the aforementioned draft Mental Capacity Act Code of Practice now has new guidance which confirms that if the person cannot understand (and/or use and weigh) the fact that there is a mismatch between what they say and what they do when required to act, it can be said that they lack capacity to make the decision in question. However, this conclusion can only properly be reached when there is clear evidence of repeated mismatch, and a single assessment is unlikely to be adequate.

[46] The draft Mental Capacity Act Code of Practice was published for public consultation on the 17th of March 2022.

[47] SCIE Report 46: Self-neglect and adult safeguarding: findings from research

6.116. In the case of Paul his mental capacity was considered by professionals over a period of time. But professionals only asked whether there was any proper reason to doubt his capacity to make a decision. Paul's inability to execute any actions went unconnected to his capacity, for example, his ability to attend his GP appointments, or reduce his drinking. True assessment of Paul's capacity required him to both inform the professional of how he would make an informed decision and demonstrate this in practice.

6.117. With regards to Paul's capacity to discharge himself from hospital, had the *Standard Operating Procedure Absconding Patients* been followed, Paul's capacity may have been given extra consideration under the process. However, it is recognised that a further challenge with assessing Paul's capacity was his alcohol use which presented the potential 'fluctuating capacity' alcohol can affect. And this fluctuating capacity isn't limited to when a person is drinking - a study[48] carried out by psychologists at the University of Bath highlights the impact heavy drinking has on the ability to plan, set goals, and make decisions the following day as hangovers can affect key cognitive processes. Knowing this, this review would ask, was Paul ever able to make decisions independent from alcohol influence?

6.118. Liverpool Safeguarding Adults Board has already been recommended in the Safeguarding Adults Review Hazel to consider commissioning multi-agency audits of mental capacity assessments and, with partner agencies, agree an action plan to address the findings. Such audits will help the Board to recognise professional understanding of executive capacity.

6.119. In the absence of effective multi-agency information sharing, the staff at the hospital were unaware that Paul was leaving the hospital to return to an extremely unkempt property and that he was unable to meet his own basic needs. Had staff had concerns, the Mental Health Act sets out a comprehensive scheme for admission of non-compliant patients and provides an authority to hold a patient during assessment with or without capacity. As such it could have also been considered to support an assessment of Paul's mental state and risk of self-harm. However, there is no ground under the Act for detaining a person in hospital on the basis of alcohol dependency alone – Paul would have required to have been suffering an accompanying mental disorder to fall within the Act's definition - but this mental disorder can be one that has resulted from the person's alcohol dependence and can include acute intoxication[49] which was how he presented in August 2020 when he was brought into the Emergency Department.

6.120. A Section 13 Mental Health Act Assessment[50] is an assessment to decide whether a person should be detained in hospital under a section of the Mental Health Act to ensure that the person receives care and treatment for a mental disorder. However, it is acknowledged that because there are limited holding powers within an Emergency Department setting, it would have proved difficult to have held Paul had he been intent on leaving before a Mental Health Act Assessment had been completed. The Emergency Department is an outpatient setting therefore a Section 5(2)[51] doctors' holding power, cannot be utilised as this only applies to hospital inpatients. And whilst a request for police to attend and consider the use of their Section 136[52] emergency powers could have been considered, the Emergency Department is classed as a place of safety in which police would usually convey someone to for assessment under this section, and so it would not always be considered appropriate to utilise this power when a person is already within the health care setting/place of safety.

6.121. Moving away from the hospital setting, Police Officers haven't documented whether they ever considered using the Mental Health Act. Although their contacts with Paul were within his home address, consideration could have been had of section 137 or a voluntary mental health assessment.

Learning 12: Detailed records must be kept of all decisions relating to mental health care including capacity assessments, and best interest decisions. This is not only good professional practice but necessary should a decision- or decision-making process be later challenged or reviewed.

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[48] The Effects of Alcohol Hangover on Executive Functions' is published in the *Journal of Clinical Medicine* https://www.mdpi.com/2077-0383/9/4/1148.

[49] Acute intoxication (by either drugs or by alcohol) is listed in the International Classification of Disease, 10th edition, published by the World Health Organisation as a mental disorder.

[50] Section 13 – Duty of approved mental health professionals to make applications for admission or guardianship Introduction The Act does not leave professionals entirely free to decide when to make an application for admission to hospital or guardianship.

[51] Section 5 (2) is a temporary hold of an informal or voluntary service user on a mental health ward in order for an assessment to be arranged under the Mental Health Act 1983. This ensures their immediate safety whilst the assessment is arranged.

[52] Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern.

Question: How can partner agencies assure Liverpool Safeguarding Adults Board that a review of record keeping processes regarding an individual's mental health care including capacity assessments, and best interest decisions, will be completed and arising issues be addressed?

7. Good Practice

The agency information submitted to this review and the discussions around Paul and James, have highlighted examples of good practice from the professionals involved. Some examples are included in the body of the report, but others include:

7.1. The electric company contacting Careline to escalate concerns following a home visit to James.

7.2. Police Officers took their time communicating with both Paul and James and managed to gain snippets of information – even though neither gentleman had a desire to speak to persons of authority.

7.3. A warrant was obtained to gain access to James in order to assess him under the Mental Health Act.

7.4. The Community Mental Health Nurse and Mental Health Care Coordinator reached out to hospital 2 when James was an inpatient.

7.5. The ambulance service and housing communicated directly with Paul's sister.

8. Improving Systems and Practice

Agencies have already made some important amendments to practice since the scoping period of this review. Some of these developments have been included in the body of this report. Others include:

8.1. In October 2021 there was a significant restructure within Housing management in Your Housing Group. The number of regional managers was increased from two to five which allows for greater monitoring and casework supervision. Tenancy Management Officers are now responsible for housing management across smaller areas, the number of Tenancy Management Officers has increased, as has the number of Antisocial Behaviour Officers. The management of Antisocial behaviour and hate crime has also changed, with all cases now triaged by an Antisocial Behaviour Officer to ensure that there is consistent and timely response to reports of Antisocial Behaviour and Hate crime. Your Housing Group also re-introduced a tenancy support service in October 2021 which works with vulnerable customers who are referred by other Your Housing Group teams.

8.2. Whilst the Complex Lives Multi-Disciplinary Team brings together all the relevant people and agencies to proactively assess, plan and co-ordinate the best way to meet the needs of people with complex lives, there are often cases that potentially meet the threshold for Adult Safeguarding. There is now a representative from Mersey Care safeguarding team within the team meetings to assess each case and provide support and advice with those cases that meet or potentially meet the Statutory Threshold for Adult Safeguarding.

8.3. The safeguarding Team at Liverpool University Hospital Foundation Trust now attend a weekly meeting that takes place as part of a weekly review of patients with "Complex Alcohol issues". Names are highlighted and discussed as part of a Multi-Disciplinary Team approach making sure all appropriate agencies have a say in a "Safe Discharge" or follow up support and these cases can now also be referred into the local Multi Agency Risk Assessment Meeting.

9. Lessons Learned and Questions to address them.

9.1. In order to address the learning identified within the report, the review would ask the Liverpool Safeguarding Adults Board to deliberate the following questions. It is the responsibility of Liverpool Safeguarding Adults Board to use the ensuing debate to model an action plan to support improvements to systems and practice.

Learning 1: Telephone communication made it hard to understand and recognise Paul's needs and the level of support required.
Question: How can partner agencies who are continuing to utilise telephone/remote consultation assure Liverpool Safeguarding Adults Board that robust procedures are in place to identify those who require a home visit?

Learning 2: The available support for ex-military is not widely known or understood by professionals.
Question: How can Liverpool Safeguarding Adults Board and its partner agencies work with Veteran HQ to ensure that all agencies and their staff are aware and understand how to refer an individual to its services?

Learning 3: Hospital staff did not consider the full range of options available to them to protect Paul when he went missing from hospital.
Question: How can the NHS Foundation Trust Hospitals assure Liverpool Safeguarding Adults Board that they have ensured that all staff, including agency staff, understand the importance of the Standard Operating Procedure Absconding Patients, and know how and when to use it.

Learning 4: There were missed opportunities to share information, escalate concerns and develop action plans with other agencies when it was recognised that professionals were failing to be effective in the engagement of the person and in the management of risk.
This learning has now been addressed with the introduction of Liverpool Safeguarding Adults Board's Multi-Agency Risk Assessment Process in October 2022. This guidance is to be used where there is concern that an individual's lifestyle or behaviour is likely to result in serious harm, or even death and single agency involvement has failed to be effective in the management of risk. Deployment of the process (had it been available within the scoping period of James and Paul) would have resulted in a Multi-Agency Risk Assessment meeting[53] being convened and a Risk Management Plan being completed. Crucially in addition to all agencies being made aware of James's and Paul's situations, the ensuing Risk Management Plan would have identified a Key Worker who would have retained overall responsibility for coordinating the plan and the review meetings would have been scheduled.
Question: How can Liverpool Safeguarding Adults Board audit the effectiveness of the Multi-Agency Risk Assessment Process.

Learning 5: Self-neglect and/or hoarding should always be addressed irrespective of how the person has come to neglect themselves i.e., alcohol misuse, mental health, etc.
The issues around self-neglect has recently been highlighted to Liverpool Safeguarding Adults Board within the aforementioned Safeguarding Adults Review Hazel. The Board should consider the action plan produced in response to Hazel against the content and learning within this report.

Learning 6: There was a missed historic opportunity to support Paul. And the missed opportunity effected the family to question their trust in professional intervention/support.
Question: How can Liverpool Safeguarding Adult Board explore whether professionals are effectively exploring concerns raised by family members regarding an individual's mental health, and if there is current concern, identify what steps can be taken to address it?

Learning 7: Professionals find it difficult to engage individuals who have 'complex lives' with long-term support difficult.
This review is assured that this learning is now addressed with the introduction of Liverpool Safeguarding Adults Board's aforementioned Multi-Agency Risk Assessment Process.

Learning 8: The learning objective of Safeguarding Adult Reviews is hindered if key frontline practitioners do not engage with the process and/or their voices are not heard.

[53] Any staff from any agency can convene a Multi-Agency Risk Management Meeting

Question: How can partner agencies assure the Liverpool Safeguarding Adults Board that their practitioners understand the Safeguarding Adults Review process and its importance? And what alternative, timely ways could the Liverpool Safeguarding Adults Board consider in order to capture the voice of the frontline practitioners?

Learning 9: There needed a multi-agency approach to achieve a clear understanding of Paul's needs as a whole – not just in relation to his alcohol misuse.
Question: How can key agencies assure Liverpool Safeguarding Adults Board that their practitioners are able to access training to improve their understanding of alcohol dependency and awareness of addiction and associated risks, and know where to refer a person to when a person's needs are not being met?

Learning 10: Professionals must be alert to signs of exploitation/mate crime and ensure that policy and procedures reflect the risk for adults at risk.
Question: How can partner agencies assure Liverpool Safeguarding Adults Board that awareness is being raised around the potential mate crime/exploitation of adults at risk, and of the wider public interest issues that arise when concerns around mate crime/exploitation/financial abuse originate (even when the criminal threshold for prosecution is not reached)?

Learning 11: Best Interest meetings could have been convened in a timelier manner and would have proven more effective with better representation.
Question: How can partner agencies assure Liverpool Safeguarding Adults Board that their practitioners understand Best Interest meetings, and that Best Interest meetings are being convened in a timely and effective manner with the correct representation?

Learning 12: Detailed records must be kept of all decisions relating to mental health care including capacity assessments, and best interest decisions. This is not only good professional practice but necessary should a decision- or decision-making process be later challenged or reviewed.
Question: How can partner agencies assure Liverpool Safeguarding Adults Board that a review of record keeping processes regarding an individual's mental health care including capacity assessments, and best interest decisions, will be completed and arising issues be addressed?

10. Appendix 1 – Panel Members

- Detective Superintendent – Merseyside Police
- Named Nurse Safeguarding Adults – Mersey Care
- Divisional Director of Nursing -Safeguarding Services – Liverpool University Hospital Foundation Trust
- Divisional Manager – Liverpool City Council Adult Social Care
- Designated Safeguarding Adult Nurse - Merseyside & Cheshire Integrated Care Board
- Safeguarding Officer – Riverside Housing

11. Appendix 2 – Summary of Parallel Investigations

Following the Mersey Care NHS Foundation Trust 72-hour review and a Level 2 Serious Incident Investigation, the following recommendations from the Level 2 investigation were identified,

1. A clear Trust wide discharge or transfer procedure to North West Ambulance Service and or Acute trust must be in place reflective of expected practice standards for joint care planning.
2. Psychiatric liaison services should support clinical meetings and provide expert guidance in respect of patients with dual, complex physical and mental health care needs. Where appropriate this should include advice regarding the use of Section 63 of the Mental Health Act, Mental Capacity, and best interest considerations.
3. Given the cardiometabolic health risk amongst the mental health population staff must be competent in recognizing the signs of the deteriorating patient.
4. The trust should review referral pathways in collaboration with Independent Mental Capacity Advocate

service providers including target response times to referrals.

5. Acute mental health inpatient wards should ensure that, in the event of a patient requiring transfer to a neighbouring acute hospital for treatment, the member of staff accompanying the patient is fully briefed and key information/documentation pertaining to the patient is transferred with them.
6. Acute mental health inpatient wards should ensure and confirm that, in the event of a patient requiring transfer to a neighbouring acute hospital for treatment, the member of staff accompanying the patient is up to date in their Basic Life Support training.
7. That the events surrounding this serious incident be considered for a Safeguarding Adults Review to focus on multi-agency learning.
8. Learning to be shared across the Mental Health Care Division

This review has been assured that learning was also identified within the rapid review completed by Liverpool University Hospital Trust.