Safeguarding Adults Review (SAR)
Executive Summary Report
'Hannah'

LIVERPOOL SAFEGUARDING ADULTS BOARD

INDEPENDENT LEAD REVIEWER: ALLISON SANDIFORD

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1. Introduction

The subject of this case is Hannah. On the day of her death, Hannah had been detained in hospital under section 136[1] of the Mental Health Act. Following her discharge, Hannah entered a car park where, a short time later, she fell off the edge. Hannah was taken to the Emergency Department but was sadly declared deceased soon after.

Following a referral by Liverpool City Council Adult Social Care, those present at the Safeguarding Adults Review sub group for Liverpool Safeguarding Adults Board in February 2024, agreed in the majority that the criteria was met[2] for a mandatory Safeguarding Adults Review under The Care Act 2014.

The purpose of a Safeguarding Adults Review is clearly defined in the Care Act 2014. It is to promote effective learning and improvement actions to prevent future deaths or serious harm occurring again. The lessons learnt for this case should be applied to future cases to ensure continuous improvement of practice. It is not the purpose of the review to hold any individual or organisation to account. Other processes exist for that including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation.

This report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant with no links to Liverpool Safeguarding Adults Board or any of its partner agencies. Allison gained experience in safeguarding whilst working for a police service. Since leaving the force in 2019, Allison has conducted serious case reviews in both children's and adults safeguarding, and domestic homicide reviews.

2. Methodology

Terms of Reference

The panel[3] identified the following key lines of enquiry[4] for the review:

- Who was Hannah and what were her care and support needs?
- What pathways did professionals follow in order to support Hannah?
- What pathways and existing safeguarding practices were available to professionals?
- How will the action plans of previously completed Safeguarding Adults Reviews support the learning identified around Hannah?

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[1] 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. A person is not under arrest when the decision is made to remove the person to a place of safety. The police power is to facilitate assessment of their health and wellbeing as well as the safety of other people around them.

[2] Safeguarding Adults Reviews

(1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

[3] See Appendix 2 for panel membership.

[4] See Appendix 3 for the areas identified to require consideration within the enquiries.

- What are the barriers professionals face with regards to achieving engagement, good practice and utilising all the relevant pathways[5]?
- What are Hannah's family's views?

It was agreed for the review to look at the 12-month period preceding the day when Hannah sadly died. But in addition, the report will include background information regarding any significant events and safeguarding issues prior to the scoping period if agencies consider that it would add value and learning to the review.

Involvement of Family and Wider Community

The Independent Reviewer and Liverpool Safeguarding Adults Board would like to offer their condolences to the family and friends of Hannah.
The subjective experiences of support and services provided to the deceased, from the point of view of family members, is an important aspect of the Safeguarding Adults Review. Liverpool Safeguarding Adults Board sent letters to both of Hannah's parents advising them of the review and inviting them to participate. Additionally, contact was made with the respective Family Liaison Officers. Father's Family Liaison Officer further communicated the review to father, but mother was no longer working with Family Liaison Support.
Neither parent has responded to the Board, and both the Board and the Independent Reviewer respect their decision not to participate.

Limitations to this Review

There have been limitations that have affected this review:
Hannah's previous employer has not responded to requests for information.
There are no records in relation to Hannah's childhood.

Parallel Reviews

Hannah's death was referred to HM Coroner. Following an investigation a Coroner's Inquest opened and concluded Hannah's medical cause of death to be multiple injuries.
In line with the Patient Safety Incident Response Framework, Mersey Care NHS Foundation Trust have completed a Rapid Review. The aim of a rapid internal review is to gather information (within a 72-hour time frame) to ensure that immediate required actions have been taken and duty of candour[6] completed. The report is then reviewed (within a patient safety panel) and a decision is made in relation to whether any further investigation is required. In this case it was decided that a further joint review should be completed between the Trust, Liverpool City Council and Liverpool University Hospital Trust. At the time of concluding this Safeguarding Adults Review, the subsequent review had not been completed and was not yet available for consultation.
Hannah's GP Practice has conducted an internal review into Hannah's unexpected death which concluded that Hannah's presentations to the hospital Emergency Department could have been brought specifically to the attention of her regular GP and improved communications between the Practice and the Emergency Departments and Mental Health team, could have helped the Practice to better understand Hannah's support needs.
As a result of police interaction, a referral was made to the Independent Office for Police Conduct. The Independent Office for Police Conduct investigation concluded the cause of death to be misadventure.

[5] The review will conduct 1:1s with key professionals to explore for example, desensitisation, trauma informed practice

[6] Duty of candour is a requirement for healthcare professionals to be open and honest with patients when things go wrong.

Confidentiality

To protect dignity and privacy, and to comply with the Data Protection Act 1998, the subject of this review is referred to under the pseudonym of Hannah.
Liverpool Safeguarding Adults Board have agreed to publish an Executive Summary, which will be available on the Board's website.
Upon publication, partner agencies will be made aware, and the improvement plan will be shared with the agencies involved.
The review has been assured by Liverpool Safeguarding Adults Board that the learning will be disseminated by means of a Post Safeguarding Adults Review Learning Event and a 7-minute briefing.

3. Analysis and Response to Key Lines of Enquiry

Following:

- examination of the information gained from the summary agency reports and documentation shared with this review, and
- discussions with professionals via 1:1 discussion and at a wider practitioner learning event[7], and
- discussion and analysis with panel members[8].

The subsequent responses have been generated to the Key Lines of Enquiry.
Lessons learned are stated within the body of the report. In relation to any lessons which have not been addressed, there are questions at the end of the report for Liverpool Safeguarding Adults Board to consider; the answers to which will drive Liverpool Safeguarding Adults Board and its partner agencies to develop an improvement plan that will respond directly to the learning.

Who was Hannah and what were her care and support needs

Hannah is described by those who knew her as well presented and articulate.
Practitioners' records identify Hannah's dominant care and support needs as being around her dependency of alcohol, and her mental health. But in addition, there is reference to Hannah:

- Being of a low Body Mass Index,
- Being homeless,
- Living with historic trauma.

Alcohol use

Case notes suggest that Hannah had been using alcohol since her teenage years.
Prior to the scoping period, Hannah was engaging with a health and social care charity; to whom she reported periods of alcohol abstinence (evidenced by breathalyser test readings of zero) and relapse. Hannah was advised against stopping and starting alcohol and the effects of alcohol withdrawal were discussed with her.
When a person struggling with alcohol addiction stops and then relapses several times, they are at risk of developing alcohol kindling[9]. This condition is a worsening of withdrawal symptoms each time the individual attempts to stop alcohol again. The body becomes increasingly sensitive to changes in neurotransmitters, as

[7] See Appendix 4 for details.
[8] Panel met on two occasions.
[9] Alcohol misuse - Risks - NHS (www.nhs.uk)

gamma-aminobutyric acid[10] floods the brain during periods of drinking too much and is suddenly stopped during periods of abstinence. Over a few cycles, the risk of developing tremors, agitation and seizures, and other long-term effects of alcohol withdrawal, dramatically increases.

Hannah's Voice

Hannah told a professional that she couldn't see her life without drink. She concluded that maybe death was her only way out – I either keep drinking and kill myself, stop eating and kill myself or jump out the window and kill myself.
On another occasion she described how one drink is too much, but a thousand is not enough, and said that she couldn't cope with the lifestyle but didn't know how to get out of it.

Mental Health

Hannah was diagnosed with Emotionally Unstable Personality Disorder[11] before she died. This is a mental health condition that affects the way people feel about themselves and others. This makes it hard to function in everyday life. The NHS website explains that an individual diagnosed with the disorder will differ from the average individual in terms of how he or she thinks, perceives, feels or relates to others.
It is not unusual for individuals with the condition to also, like Hannah, have another mental condition or behavioural concern, such as alcohol use, and/or an eating disorder, and to attempt self-harm and suicide.
On the day of her death, Hannah was diagnosed with a Behavioural Disorder due to alcohol dependency syndrome.

Hannah's voice:

- It is unclear from case notes how much Hannah understood of her mental health. When she was in the mental health hospital awaiting treatment, she told a professional that it was drink that was the problem. And on another occasion, she said that the self-harming behaviour and suicidal ideation was a result of her being unable to cope with her lifestyle.

Low Weight

Hannah disclosed to professionals that she had a difficult relationship with food. This prompted a referral to the Eating Disorder Clinic. An eating disorder is a mental health condition where you use the control of food to cope with feelings and other situations[12].
It is not clear when Hannah's disorder began but she had once disclosed that it pre-dated her alcohol dependency. During the scoping period of this review Hannah's statistics evidenced that her Body Mass Index was in the underweight category.
Case notes confirm that Hannah tried to control her weight by consuming few calories and exercising.

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[10] Gamma-aminobutyric acid is a neurotransmitter, a chemical messenger in your brain. It slows down your brain by blocking specific signals in your central nervous system (your brain and spinal cord). Gamma-aminobutyric acid is known for producing a calming effect. It's thought to play a major role in controlling nerve cell hyperactivity associated with anxiety, stress and fear.

[11] Emotionally Unstable Personality Disorder, also known as borderline personality disorder, is characterised by significant instability in interpersonal relationships, self-image, and emotions. People with Emotionally Unstable Personality Disorder may experience intense mood swings, feelings of emptiness, and impulsive behaviour.

[12] Overview – Eating disorders - NHS (www.nhs.uk)

Hannah's voice:

- Hannah knew that her weight was low. Whilst in rehabilitation, Hannah told a GP that because she wasn't drinking, she was now controlling her eating. Hannah said that she needed to control something.

Homelessness

Hannah had spent time living with both of her parents at their respective homes, but during the scoping period of this review, Hannah disclosed that neither parent wanted her at their home address, and she presented as homeless. There are times when Hannah disclosed sleeping rough and/or sofa surfing.
It is known that at the beginning of the scoping period, Hannah was working. However, Hannah was in receipt of an email from the company's Human Resource unit which outlined disciplinary points, and she was waiting to hear whether or not she was to be dismissed. Consequently, Hannah's income was unstable, and this would have impacted her accommodation options.

Hannah's voice:

- Hannah informed professionals that her relationship with her parents was strained. Though historically they had financed private rehabilitation for Hannah[13], it is recorded that both parents would continue to drink around Hannah.
- Hannah had a strong relationship with an aunt. Her aunt did not live locally but was reportedly willing to 'take Hannah in' and support her. However, Hannah told a practitioner that she didn't think it was fair 'to put on her'.
- Hannah's voice suggests that she found it challenging to live with either of her parents and considered herself to be a burden to others.

Trauma

Hannah engaged in Cognitive Analytical Therapy during the scoping period, but she found it too difficult to continue due to past trauma. The details of Hannah's trauma remains unknown, but the effects of trauma can last for a long time and can be wide-ranging. They may include emotional distress, intrusive memories, changes in mood and cognition, and altered patterns of behaviour. Trauma can also affect an individual's relationships, self-esteem, and overall quality of life.

Hannah's voice:

- Hannah potentially used alcohol and/or other substances to manage her emotions. Alcohol would have initially seemed to relieve the symptoms of her traumatic experiences because it would have caused her brain to release endorphins which help numb physical and emotional pain. This is the body naturally helping an individual to cope, but it interrupts the natural protective function the body is already doing[14].
- Hannah knew how to ask for help – and often did. For example, Hannah contacted both the ambulance service and the police; and would (when she felt able) engage with assessments. Also, prior and during the scoping period of this review, Hannah attended and engaged with rehabilitation. However, professionals' ability to engage Hannah outside of these windows of opportunity was inconsistent. Hannah provided insight into what she thought the barriers were, when she said that she *struggled to trust anyone.*

[13] Hannah's mother is reported to have said that each time Hannah returned, her condition worsened.

[14] GoodTherapy | Alcohol and Trauma: Drinking as a Way to Co...

What pathways did professionals follow in order to support Hannah, and what pathways and existing safeguarding practices were available?

Within the scoping period of this review, Hannah:

- attended hospital Emergency Departments,
- had contact with the ambulance service and the police,
- was referred to Adult Social Care,
- engaged with alcohol support services,
- was assessed for her mental health,
- was registered with GP Practices, and
- met with a homeless charity.

The following support was offered as a result.

Liverpool University Hospital Foundation Trust

Within the scoping period of this review, Hannah presented at two of the Liverpool University Hospital Trust hospitals (hereafter known as Hospital 1 and Hospital 2) requesting support for an alcohol addiction and mental health issues. She also sometimes presented at other hospitals.

The Liverpool University Hospital Trust hospitals share the same computer system and as such staff and practitioners working in whichever hospital would have been able to see when Hannah had presented at either Emergency Department, on their database. But Hannah's presentations to hospitals outside of the Liverpool University Hospital Trust group would only have been visible by using the Care and Health Information Exchange system[15] - which this review has been informed, is not routinely checked.

Hannah usually attended the Emergency Department under the influence of alcohol. Practitioners have informed this review that such presentation is not unique to Hannah, and that individuals who present as Hannah did; heavily intoxicated, vomiting, sometimes agitated and not always wanting to wait for treatment - whilst commonplace, can potentially be uncomfortable for other Emergency Department users. For example, Hannah would sometimes argue with staff and/or often lie on the floor[16] (even if a wheelchair had been provided). Nevertheless, a practitioner working in the department has assured this review that their priority was always to make sure that Hannah was safe in their waiting room.

This review has explored what treatment and support options were available to practitioners attending to Hannah in the Emergency Department whilst intoxicated, and has identified that they could offer:

- Fluids to support sobering up.
- Treatment for withdrawal symptoms.
- A referral to the hospital Mental Health Liaison Team who would then assess Hannah's mental health and create an action plan.
- A referral to the hospital Alcohol Liaison Team who would then consider hospital detox and/or onward referrals to community alcohol support services.
- A referral to the hospital safeguarding unit.

This review has learned that when Hannah stayed in the Emergency Department long enough to be seen by practitioners, the above options were discussed, medical treatment was administered

[15] The Care and Health Information Exchange is a secure system which shares health and social care information from GP surgeries, hospitals, community and mental health, social services and others.

[16] It required two practitioners to lift her back up.

appropriately, and referrals were made to either the Alcohol Liaison Team, the Mental Health Liaison Team, or both. How Hannah thereafter responded to the support subsequently offered, was out of the remit of the Emergency Department practitioners.

A practitioner working in the Emergency Department shared her frustrations with the Independent Reviewer around not being able to engage Hannah more. She described how she would feel as if,

- she was starting to build a rapport with Hannah and
- that Hannah was listening, and potentially starting to feel more able to accept some help,

but then Hannah would suddenly leave halfway through a consultation. The practitioner informed that she never had reason to doubt Hannah's capacity to make this decision to leave.

When Hannah was intoxicated to the point that her mental capacity could not be assumed and left the Emergency Department after she had been booked in, professionals had an ethical duty of care towards her to protect her life - and a legal duty of the state to protect her article 2 right to life. However, this did not permit professionals to restrict her liberty disproportionately or illegally.

Had Hannah been suffering an accompanying mental disorder she would have fallen within the umbrella of the Mental Health Act (notably this mental disorder can be one that has resulted from the person's alcohol dependence and can include acute intoxication[17]) which sets out a comprehensive scheme for admission of non-compliant patients into hospital and provides an authority to hold a patient during assessment with or without capacity.

There are examples within the scoping period of professionals utilising the Mental Health Act. For example, on two occasions, Hannah was brought to hospital by Police Officers under Section 136 of the Mental Health Act (and on occasion Hannah was detained in hospital under Section 2 of the Mental Health Act).

However, professionals working in the Emergency Department do not have the powers to detain an individual under the Mental Health Act 1983. Their options are limited to requesting a Section 4[18] or a Section 2[19] assessment - and organising these assessments takes time. Without powers to detain (within the Emergency Department setting), it was difficult to hold Hannah if/when she was intent on leaving before assessment[20]. This demonstrates the urgent need for the introduction of an emergency holding power which can be used in Emergency Department settings. Such a power would help to keep people presenting at hospital Emergency Departments in similar circumstances as Hannah, safer and away from harm.

Whilst this review appreciates that the fast pace of the Emergency Department can often result in the practitioner needing to make an immediate decision with incomplete information[21], as mentioned, once Hannah had been booked into the Emergency Department a duty of care existed, and

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[17] 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

[18] Section 4 of the Mental Health Act is an emergency application for detention in hospital for up to 72 hours. It requires only one medical recommendation from a doctor and the application is usually by an Approved Mental Health Professional, on very rare occasions it can be applied by the Nearest Relative.

[19] Section 2 is part of the civil sections under the Mental Health Act. It provides for someone to be detained in hospital under a legal framework for an assessment and treatment of their mental disorder.

[20] The Emergency Department is an outpatient setting therefore a Section 5(2) 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 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.

[21] The Patient who Absconds June 202

professionals therefore had a duty to consider whether Hannah was at risk of harm and actively manage the risk if she was.
This review has been informed that on such occasions, security staff would be asked to keep an eye on Hannah and to alert practitioners if she left the hospital grounds. There are a few police reports which evidence that when Hannah left the grounds of hospital 2 and professionals had concerns, they contacted the police who would then attempt to locate Hannah. This is in line with the hospital Emergency Departments' written guidance which outlines the actions to take if a patient absconds; and advises when it is appropriate to contact the Police Service.
Professionals who work in the hospitals' Emergency Departments have described the departments as chaotic and relentless. They explained how the chairs within the waiting room are hard, plastic and uncomfortable, and amongst the acutely physically ill, will be patients with mental health issues (who are deemed to have capacity), individuals who have used substances, and often, homeless individuals who have poor access to other services and have nowhere else to go to be warm and safe. Often these individuals will be associated, and the atmosphere can become raucous, and tensions can arise. One professional described how there is only one triage nurse to oversee all these people, and it can sometimes be quite scary dealing with everyone. Furthermore, they expressed concerns about the adequacy of their training to handle such unpredictable situations.
This review has learned that sometimes Hannah would be asked to leave hospital Emergency Departments due to drinking alcohol on the premises, and her behaviours. Whilst there is no doubt that any violence – including alcohol related violence – towards professionals working in the Emergency Department is unacceptable, it should be remembered that Hannah, when under the influence of alcohol would have responded and acted differently to how she would when sober. For example, Hannah would have been less likely to conform with requests, more likely to act irrationally and more likely to over-react.
Understandably case notes indicate varying degrees of professionals' interpersonal skills to manage and defuse this behaviour, and there are occasions when police have been requested to assist with Hannah's behaviours.
Notably police records evidence that on one occasion police were called to hospital 1 and asked to remove Hannah because she was being violent. By the time Officers arrived, Hannah was sleeping but professionals at the hospital said that she was medically fit and needed to be removed from the premises. Hannah left in a taxi - but hours later hospital 1 re-contacted the police reporting Hannah to be back and violent. Officers established that Hannah had been returned by ambulance due to suffering a seizure and they were told that hospital staff had refused to treat Hannah as she had already been seen and deemed to be medically fit that day. Consequently, Officers had to transport Hannah to hospital 2 - where medical professionals agreed that she required treatment.
Liverpool University Hospital Foundation Trust has informed this review that it recognises that the majority of service users and patients are not violent and should not be perceived as such and also that the causes of violence and aggression within healthcare settings are often complex and can be attributed to many factors. However, it is acknowledged that there are instances when staff and service users are faced with potentially violent or aggressive incidents and as such the Trust has a policy entitled 'Violence Prevention and Reduction' which sets out the Trust commitment and approach to providing a safe and secure environment for staff, patients, and visitors - free from violence and abuse. The Policy sets out the procedures to be followed by staff to ensure that all incidents of violence and aggression are reported and dealt with appropriately. The procedure for managing violent, aggressive, or unacceptable behaviour is described in the policy; each case should be looked at individually to ensure that the need to protect staff is properly balanced against the need to provide healthcare to individuals. The overall aim will be to stop or diffuse unacceptable behaviour and to prevent it from

developing into more serious situations. In the event of violent and abusive incidents reported, there are sanctions (Verbal Warning, Written Warning, and Withdrawal of Treatment) available to the trust as a mechanism whereby extreme or persistent behaviour, as a last resort can be applied.
The Hospital Leadership Team for each site make the final decision in relation to 'withholding of treatment[22] and a patient would subsequently be issued with a final written explanation of the reasons to exclude them from the premises and the withholding of treatment. The letter will
make it clear that the withholding of treatment is time limited for a period of no more than 12 months

- detail the patient's right to appeal the decision, and
- be copied to the patient's General Practitioner and the Trusts Security Management Team.

(A detailed record of the rationale for exclusion and of alternative arrangements for care is maintained in the patient's medical notes.)

This review has not been informed of any documentation within case notes which would suggest that Hannah was ever issued with any of the aforementioned warnings or a withholding of treatment letter. But in relation to how staff at the Trust are now being supported to manage violent and aggressive behaviours, this review has been assured that the Trust has an Executive led programme of work, 'Building a Kinder and Safer Liverpool University Hospital Foundation Trust'. This work aims to see a reduction in the number of incidents of violence and aggression and the drivers include prevention and intervention, staff and patient engagement and education, data and learning. The work is also underpinned by a range of other schemes including trauma informed practice, de-escalation training, wayfinding, security risk assessments and staff education and training.

Professionals at the learning event voiced their frustrations in relation to how overused hospital Emergency Departments are, and how individuals presenting with mental health issues and/or substance use need specialist professionals to support them – preferably in an approved area accessible 24/7.

In relation to homeless people gathering at hospital Emergency Departments to keep warm and safe, this review is assured to learn that in November 2024, Liverpool City Council launched a public consultation on proposals to tackle homelessness and rough sleeping in the city. The Council has set out a draft five-year strategy outlining a number of plans for the prevention of homelessness and for ensuring sufficient accommodation and support is available[23].

Also, a panel member of this Safeguarding Adults Review, has helpfully brought a podcast[24] to the attention of the Independent Reviewer which the review recommends the Liverpool University Hospital NHS Foundation Trust consider sharing with their staff. The podcast discusses the challenges people experiencing homelessness face when attending hospital Emergency Departments and the challenges for staff. There are also some useful resources on the website[25].

Liverpool University Hospital NHS Foundation Trust holds 'frequent attenders' meetings. These are multi-disciplinary meetings which often form part of the Trust Board meetings and are held monthly. It is clear that Hannah's significantly frequent hospital attendances were recognised by the Trust as she was discussed within these meetings. However, this review has been informed that when she was

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[22] Withholding treatment will not be applied to the following patients: • Patients, who in the expert judgment of a relevant clinician are not competent to take responsibility for their action, e.g., an individual who becomes violent and aggressive as a result of an illness or injury. • Patients with mental health issues, dementia or have learning disabilities. • Patients, who in the expert judgment of a relevant Clinician, require emergency treatment, • Other than in exceptional circumstances, minors under the age of 18 years

[23] Liverpool Homelessness and rough sleeping

[24] Going Beyond: Homeless Link Practice Podcast | Homeless Link (podbean.com)

[25] Improving Accident and Emergency (A&E) experiences | Homeless Link

discussed, it would have been as one of many and in relation to action planning, there would have been no continuity from one 'frequent attenders' meeting to the next.
Hannah would have benefitted had the meeting considered utilising the Multi-Agency Risk and Management protocol (this protocol is explained in detail later in the report). Exploration as to why this wasn't considered has concluded that there is a poor professional understanding of who should follow the protocol and in what circumstances.
This review has also learned of some ongoing work which it is expected will support practitioners with high intensity users of the Emergency Department in the future.

- A High Intensity Use Task Group has been established whose primary focus is to reduce high intensity use of emergency and acute services by providing rapid response pathways into more effective support in the community. Secondary aims include improving patient outcomes, reducing moral distress caused to staff working in first level services, and reducing non-elective admissions.
- The Task Group will meet monthly (or less frequently if required),
- To establish a co-ordinated and fast-flowing pathway into support services for high intensity users of Liverpool University Hospital NHS Foundation Trust emergency services in Liverpool
- To improve understanding of the local picture in terms of health need and patterns of service utilisation, setting targets and trajectories as appropriate
- Engage relevant stakeholders from across the whole system in the development of a local response
- Assess risks to the High Intensity Users programme and ensure appropriate mitigating actions are in place
- Resolve all high-level project issues, escalating for resolution to relevant management teams as appropriate
- Take responsibility for project communications
- Formulate programme plans for the workstream including development, testing, implementation and communication.

The Task Group will have a dual line of reporting into the Urgent and Emergency Care programme board in relation to high intensity users activity levels, and into the Community Services Review programme in relation to community and neighbourhood-based developments.
Hospital 1 exampled positive practice when a safeguarding concern was submitted to Adult Social Care in regard to Hannah presenting in an unkempt state with excess alcohol consumption and leaving prior to being seen – and as a result, Adult Social Care undertook a safeguarding enquiry. However, a missed opportunity to submit a safeguarding referral has been identified when Hannah disclosed an incident which occurred in the Emergency Department of hospital 1. Though the hospital undertook an internal investigation and involved the police appropriately, the incident was not deemed to fit the criteria for a safeguarding referral to Adult Social Care by either the hospital or the police.
This has been discussed with professionals who have reflected that this decision suggests that the local authority's response was effectively pre-empted, and that it would have been beneficial to submit a referral - as even if the criteria were not deemed to have been met, it would have contributed to Adult Social Care developing a fuller picture of Hannah's lived experience.
Within these discussions it was brought to the attention of this review that Hannah had been discussed within multi-disciplinary meetings which included a Social Worker, whilst she was an inpatient. Consequently, there was a presumption that if anything mentioned warranted Adult Social Care safeguarding/intervention, it would be actioned by the Social Worker present.
In summary when Hannah presented at the hospitals' Emergency Departments she was medically treated if required (unless professionals were unable to manage her behaviours) and referred to

mental health and alcohol services as appropriate. The hospital was clearly concerned for Hannah as she was discussed in hospital meetings and on one occasion a referral was submitted to the safeguarding team, but Hannah's circumstances needed to be shared and thereafter monitored within a multi-agency forum.

On occasions during the scoping period of this review, Hannah either attended or was taken to hospital Emergency Departments that were not part of the Liverpool University Hospital Foundation Trust. Namely a Mersey and West Lancashire Teaching Hospital - NHS Acute Provider (Knowsley Borough) and a Mersey and West Lancashire Teaching Hospital – Southport Hospital (Sefton Borough).

This review has considered their summary agency reports within its process and has not identified any learning for them in relation to Hannah's case - but would recommend that this report is shared with both organisations for their consideration.

Learning Points in relation to Liverpool University Hospital Foundation Trust:

- ***Managing alcohol related behaviours is complex in regard to the difficulties professionals face when communicating with individuals exhibiting alcohol related aggression.***
- ***Professionals working within Liverpool University Hospital Foundation Trust did not refer Hannah to safeguarding when she disclosed an incident. This chanced Adult Social Care being unaware of the full risks for Hannah and is contrary to safeguarding procedures.***

Mersey Care NHS Foundation Trust - Mental Health Trust

Mersey Care NHS Foundation Trust service offer includes hospital mental health liaison teams. These teams offer a 24 hour service based at the three Emergency Departments in Liverpool and Sefton. The teams provide support for individuals who are identified in the Emergency Departments as having a mental health issue.

Two specialist teams also support adults who are inpatients and who display signs of a mental health problem, so they can be assessed and directed the appropriate services.

Mersey Care NHS Foundation Trust also provide telephone support for people experiencing a mental health crisis and the chronology evidences that Hannah's family was able to utilise this.

During Hannah's first presentation in the scoping period of this review with the hospital mental health liaison team, she informed that she struggled with trauma and couldn't stop drinking. Whilst this review has not been informed of what detail of the trauma was recorded, it is pertinent that a month later in the scoping period (following Hannah having been detained under section 2 of the Mental Health Act) a Consultant Psychiatrist referred Hannah to a specialist psychotherapy service as part of her discharge (Hannah had reported two incidents). Historic trauma is not recorded within Hannah's notes, but it is noted that she had identified a breakdown of a relationship with a partner as being a precipitant to her alcohol use (the breakdown had occurred a few years prior to the scoping period of this review).

The day following Hannah's discharge from the section 2, she was referred to Hospital 2's Mental Health Liaison Team due to suicidal ideation. A mental health assessment was attempted but not completed as Hannah was intoxicated. This is a common barrier to mental health assessment as it is very difficult to assess mental health when a person is under the heavy influence of alcohol. The influence of alcohol effects impaired capacity, but the code of practice promotes waiting for capacity

to return (in the absence of immediate risks triggering a best interest's decision) which in the case of someone presenting as Hannah did, is likely to happen once the effects of the alcohol have subsided. Following this presentation there is evidence of Hannah reaching out for crisis support and being seen by a practitioner of the Mersey Care NHS Foundation Trust Mental Health Triage Team. The practitioner arranged for Hannah to go the Emergency Department for alcohol detox but again Hannah was too intoxicated to undertake an assessment with the liaison team. Instead, it was decided that a referral would be made to mental health following medical detox when Hannah was fit.

Interventions continued during Hannah's times of crisis but positively, Hannah had started to work with a further strand of Mersey Care NHS Foundation Trust, that being the Liverpool Community Alcohol Service. And she was, by now, awaiting rehab. During this waiting time a referral was made to the Crisis Resolution and Home Treatment Team, who made plans to visit Hannah daily at her father's address.

It is positive that Hannah's family were able to contact the Crisis Resolution and Home Treatment Team when they struggled to manage Hannah's addiction in the home.

It is not clear what assessment had been made of dad's ability to manage Hannah, or what support he may have needed, or whether there is any service operational procedure reflecting the consideration required of a third party's ability to contribute to an individual's support plans in such circumstances.

Whilst Hannah was in rehabilitation, the Mersey Care NHS Foundation Trust Eating Disorder Service received a referral for Hannah from her GP. At that time, it was noted that the waiting period for the Eating Disorder Service therapy would likely exceed the 18-week target. The GP was advised to continue monitoring Hannah's mental and physical health while she awaited therapy, and to contact the Eating Disorder Service if her health, weight, or mood deteriorated, so that her priority could be reassessed. The Eating Disorder Service provided written guidelines for the GP on monitoring her condition and steps to take if results were abnormal, which could be sent via post or email.

Following Hannah's discharge from rehabilitation, the cycle of her presenting at the Emergency Department in crisis and being referred to mental health services continued.

The week before Hannah died, a hospital alcohol liaison nurse from hospital 1 referred Hannah back into Liverpool Community Alcohol Services citing a diagnosis of Emotionally Unstable Personality Disorder, Depression, and Alcohol Misuse Disorder, along with a history of cocaine use and unstable housing and on the day of her death, Hannah was diagnosed with a Behavioural disorder due to alcohol dependency syndrome during a Mental Health Act Assessment.

Whilst it is positive that Hannah was referred back to alcohol services in order to address the addiction, these diagnoses example that Hannah's mental health was concluded to be secondary to the alcohol addiction.

Furthermore, the omissions of safeguarding referrals when for example during consultations, Hannah,

- disclosed incidents,
- homelessness, and/or
- exampled potential self-neglecting behaviours in the form of a failure to access services,

indicates a lack of recognition that Hannah may have had adult care and support requirements, and/or an unconscious bias that such issues are to be expected when an individual is living an addiction that effects a lifestyle that could be said to be *chaotic*.

At the least, given that Hannah's presentation to mental health services escalated over time, with multiple incidents indicating addiction and suicidal ideation, consideration could have been had in regard to how to increase coordination and collaboration between the agencies involved. This could have been achieved using the Multi Agency Risk Assessment Management process. Professionals at

the learning event identified that this didn't happen because professionals working for Mersey Care services generally aren't aware of the Multi Agency Risk Assessment Management process.

This review has been assured that Liverpool Safeguarding Adults Board has recently reviewed its Guidance on how to identify and respond to adult safeguarding concerns. The guidance is for use by all agencies, in the public, private and voluntary sectors. It is directed towards practitioners and aims to ensure safeguarding concerns are reported and responded to at the appropriate level with a consistency of approach across agencies.

Notably all of Hannah's contacts with Mersey Care NHS Foundation Trust services had similar outcomes and discharge plans, and Hannah's treatment plans appear to have focused primarily on alcohol, with less emphasis on addressing any underlying mental health issue. Yet Hannah's use of alcohol was likely a manifestation of her using alcohol to try and eradicate any unwanted intrusive emotions. She potentially used alcohol to manage traumatic feelings and thoughts.

A practitioner from the mental health liaison team informed this review that the most recent clinical literature does appear to show that unresolved trauma is often linked to addictions and that this in turn increases the risk of deliberate self-harm, suicide attempts and/or impulsive or reckless acts. As such identifying the cause of trauma and addressing it early with psychological therapies can help prevent maladaptive and risky coping mechanisms and therefore reduce the risk of impulsive or reckless acts. The cycle of behaviours needs to be addressed to support individuals to gain insight, learn risk reducing coping mechanisms, and to become more self-aware.

Learning Points in relation to Mersey Care NHS Foundation Trust:

- ***Professionals working within Mersey Care NHS Foundation Trust did not consistently refer Hannah to safeguarding when she disclosed social issues which included trauma, and homelessness to consider how best to achieve multi-agency action planning. This affected Adult Social Care's ability to understand Hannah's full picture.***
- ***Many professionals working for Mersey Care services (in particularly within liaison services) are unaware of the Multi Agency Risk Assessment Management process.***

GP Practice

Hannah was registered with two GP Practices during the scoping period of this review. To put the GP Practice's workload into context, Practice 1 has approximately 9,000 patients and Practice 2 has four Practices in Liverpool with approximately 85,600 patients on their register.

Case notes evidence that Hannah felt able to utilise both GP Practices and that GP's from both Practices had significant conversations with her in which Hannah was open about her alcohol use and health concerns. The GPs responded appropriately to Hannah, providing prescriptions and sicknotes.

When partway through the review scoping period, Hannah changed GP Practice, both her medical records and forthcoming hospital discharge notifications ensured that the new Practice (Practice 2) was aware of Hannah's complex issues with alcohol and mental health. Practice 2 initially attempted to make contact with Hannah (by text) but was unsuccessful. However, within weeks, Hannah contacted the surgery herself requesting a sick note - which the GP prescribed. Given Hannah's complexity there was a missed opportunity at this time to ask Hannah to attend the surgery to meet a GP and discuss her care needs.

Following receipt of further hospital discharge notifications, Practice 2 contacted Hannah by text, inviting her to make an appointment. This review has discussed whether a phone call may have been more efficient, and the Practice agreed but explained that owing to the very large number of notifications received daily by the Practice, this could prove difficult.

The pattern of hospital notifications, and the GP Practice attempting contact, continued until Hannah whilst in rehabilitation, contacted the Practice online, provided information about herself and requested blood tests. From here on, a GP at Practice 2 engaged Hannah well and it was positive practice that thereafter Practice 2 did its best to ensure that Hannah always saw the same GP – though this has its limitations owing to the working hours of the GPs.

The Independent reviewer has discussed with both GP Practices whether the Complex Lives process could have been utilised in regard to offering Hannah further support.

Complex Lives is a multi-agency process which involves organisations in the community planning how to support an adult who has more than one health or social care need. Therefore, had Hannah subsequently become subject to this team, the resulting approach would have brought together relevant professionals/agencies to proactively assess, plan, and co-ordinate the best way to meet Hannah's needs.

Practice 1 has explained that Complex Lives was not utilised by their Practice because Hannah was already receiving support in the community. Similarly Practice 2 explained how during their contact with Hannah, she was a resident in rehabilitation services and was doing well. Both Practices described how Hannah always presented well. She was articulate and able to tell GPs what support services were available to her and how to access them. She would also demonstrate an intent to use the services and describe wanting to get better.

Following Hannah's relapse and discharge from rehabilitation she made an appointment to see her GP at Practice 2. Unfortunately, this is the only appointment that couldn't accommodate her seeing her named GP. It was positive that her named GP contacted Hannah by telephone and offered her the opportunity to either postpone the appointment or to see another Doctor. Hannah chose to see another Doctor and asked the Doctor for a letter of support to enable her to return to the recovery hub support service and to Residential drug and alcohol rehabilitation Service. As usual, Hannah presented well and said that she had an appointment with Brink the following day. There is no reference to a referral to Complex Lives being considered – but this is likely because Hannah showed an intent to access support services independently and knew what to do.

Similarly, either GP Practice could have led on the Multi-Agency Risk and Management protocol but as with the Complex Lives process, Hannah's presentation and vocalised willingness to seek and accept support, negated its consideration.

When an individual has attended an Emergency Department or is discharged from hospital, the hospitals are required to send a discharge summary to the patient's GP Practice within 24 hours to ensure continuity of care. The discharge summary should include details about the patient's treatment, medications and any follow up care needed.

Both of the GP Practices have highlighted to this review a need to improve the hospital discharge notification system to allow them to see any concerns more clearly in the first instance. Professionals attending the learning event agreed and noted that it would be helpful if the forms included more prompts for detail. In particular, around any safeguarding concerns - which this review has been informed are not being routinely recorded and disclosed to the GP.

To support the discharge notification process at the GP end, Practice 1 has informed the review that since the scoping period they have introduced a Hub to their Practice, and all coding and documents are now managed centrally by a trained team supported by senior operational mangers. This ensures that any concerning or urgent documents are managed safely and in a timely manner, or are highlighted for clinical input if necessary, and that patients with a number of hospital admission/discharges are now identified and invited into the Practice for a review.

In addition, if a patient discharge notification identifies a need for the individual to make an appointment with the GP, Practice 1 has incorporated vulnerable patient appointment slots into every

clinician's clinic across all sites. This allows for either a telephone or face to face appointment to be reserved for those more vulnerable patients who do not manage to call through early morning.
Practice 1 also discussed the Special Patient Note. The Special Patient Note is a web-based system which allows a GP Practice to enter information on to the system which is used by both NHS 111 and GP Out of Hours. The Special Patient Note can be used to highlight information about patients, like Hannah, with complex needs. It was questioned why this approach could not become more 'joined up' and used in hospitals.

Learning Points in relation to Integrated Care Board:

- ***Hospital safeguarding concerns are not being routinely recorded and disclosed to the patient's GP within hospital discharge summaries.***

The Ambulance Service

The ambulance service attended Hannah frequently during the scoping period and transferred her to hospital for assessment and treatment as appropriate.
Because of the way the ambulance service operates, the likelihood of the same clinicians being present with Hannah for each interaction is limited and as such she would have unavoidably been expected to repeat the history of her conditions multiple times. Unfortunately, this review is unable to establish how this made Hannah feel, but the review has been assured that the potential frustration this may cause a patient has been recognised and that the issue has been somewhat alleviated by means of Electronic Patient Records[26].
Positive practice is exampled by the ambulance service when a safeguarding referral was submitted following Hannah's disclosure of an incident. Interestingly, when the ambulance crew were discussing the referral with Hannah, her father and aunt were present.
In August 2023 Hannah came to the attention of the ambulance service's High Intensity team. An individual is referred into this team if an ambulance has been deployed to them on five occasions or more in one month from their home address. When Hannah came to the attention of the High Intensity team, they notified her GP of the increased contacts who sent Hannah a message offering contact.
It is within the High Intensity team's remit to convene a multi-agency meeting but this review has learned that in the midst of the volume of referrals the team receive, Hannah did not stand out as in need of this response - though it must be remembered that the team would have been unaware of any deployments to Hannah away from her home address, or other incidents whereby Hannah either took herself to hospital or was taken by the police, and of the fact that Hannah went off the ambulance service radar in September, October and November, only because she was in a residential rehabilitation centre.

Adult Social Care – Safeguarding Enquiries and Mental Health Act Assessments

In August 2023 Adult Social Care received a safeguarding concern from hospital 1, the police and the ambulance service. The hospital concern was around self-neglect, and the police and the ambulance

[26] Electronic Patient Records have been recently introduced into the ambulance service and allow operational crews to access some of the information held by a GP. However this review has learned that the information visible varies between GP Practices (and with regard to Hannah the information was minimal because she hadn't given consent for a higher disclosure), and whilst Electronic Patient Records are an important development for the ambulance service - as viewing the information could support crew to formulate the most appropriate onward referral or treatment options, the ambulance crew don't always have the time (or sometimes the need) to refer to them.

concerns were in relation to incidents. Hannah had not wanted to involve the police with the incident but had consented to a safeguarding concern as she said that she needed support.
The Front Door (who managed the incoming referrals) combined the concerns into one concerns form and forwarded it to the community Adult Social Care team who commenced a safeguarding enquiry.
Hannah's case was allocated to a community Social Worker who successfully engaged Hannah, but Hannah declined a Care Assessment stating that she did not need support at the time because she was attending rehabilitation the following day. It was positive practice that the Social Worker linked with the rehabilitation provider and confirmed admission before the safeguarding enquiry was closed.
Because the individual concerns reported by hospital 1, the police and the ambulance service, had been combined at the Front Door, the concerns raised by the police and the ambulance service were not obvious. Consequently, the focus of the enquiry was on the self-neglect which was deemed to be being addressed by means of alcohol rehabilitation.
Consideration could have been had in regard to sharing the information with other professionals to trigger a multi-agency response. Although it must be acknowledged that because Hannah was attending rehabilitation the following day, the immediate risk to her would have significantly reduced and therefore a strategy meeting or other multi-agency meeting may not have convened anyhow.
In December 2023 the rehabilitation provider referred Hannah to Adult Social Care (both by telephone and by means of the portal) following her placement breaking down. On this occasion the community social work team attempted to contact Hannah by telephone but the number they had did not connect and they had no telephone contact details for Hannah's father. The team communicated with hospitals, the rehabilitation provider and the homeless outreach team but Hannah's whereabouts remained unknown.
A few days later the rehabilitation provider informed the community social work team that Hannah had been seen safe and well. It was positive practice that whilst this information effected a decrease to the concerns for Hannah, Adult Social Care did not close the case as they had not yet spoken with Hannah directly.
At the beginning of January, a Police Vulnerable Persons Referral Form evidenced that Hannah was in hospital. The following day a Social Worker was allocated to Hannah's case with the intent to visit her but there was a missed opportunity at this time to convene a strategy meeting which would have enabled a coordinated response with regard to Hannah's current presentation and needs. Sadly, Hannah passed away before she was seen by a Social Worker.
In addition to the community team, Adult Social Care's Approved Mental Health Professional team was involved with the support offered to Hannah (as the Mental Health Act Assessments were completed jointly).
The team report that Hannah presented in assessment as eloquent and intelligent and demonstrated a good insight into her behaviours and risk. Hannah did not present as depressed or with any mental illness when seen by the team. Consequently, there was no rationale or scope for action under the Mental Health Act and the team could only offer onward referrals.
This review has heard that when sober, Hannah would always offer reassurances in regard to who she was going to seek support from, and how, but case notes evidence a pattern. There would be a concern whilst Hannah was intoxicated – which would result in a Mental Health Act Assessment request – which would be undertaken with Hannah when she was sobered – by which time Hannah would be rational and without suicidal ideation. The repetition of this pattern would suggest that a different plan or outcome was needed, and that the concern required to be escalated – potentially through the Multi-Agency Risk and Management protocol.

Learning Points in relation to Adult Social Care:

- ***The combined safeguarding concern form did not clearly highlight all of the concerns raised on the individual concern forms.***

Merseyside Police

Police were heavily involved with Hannah during the scoping period. On occasions, Hannah contacted the police herself and asked for help; and other times, police were called to assist others to manage Hannah's behaviour when she was intoxicated or displaying suicidal ideations, for example hospital staff, shop workers, ambulance crew. Though some behaviours led to Hannah being arrested/charged for public order offences, Police Officers regularly took Hannah to hospital for healthcare assistance.

On three occasions Hannah reported incidents to the police, but she did not wish to support any investigation. Hannah is recorded to have said that she thought assisting with an investigation would *give her undue stress that could be detrimental to her recovery from alcohol.* It was positive practice that investigations were filed with the agreement that Hannah could re-contact Officers, if or when, she felt more able.

Police records suggest an escalation in Hannah's suicidal attempts. It was positive practice that on occasion, when necessary to support Hannah, Officers detained her under section 136 of the Mental Health Act. However this review has learned of an occasion whereby Hannah was taken to hospital informally by Police Officers in a distressed and agitated state and hospital staff in the Emergency Department Mental Health Liaison Team encouraged Officers to utilise their powers under section 136 to detain Hannah and ensure her safety - as it was recognised that she was too intoxicated to immediately undertake assessment. Officers agreed and Hannah was taken to the 136 suite, but this review has been informed that there was a reluctance on behalf of the Officers. This reluctance is understandable as 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. However, Officers should only be moving an individual about in the first place either with consent or with a legal framework (i.e., section 136).

This review has been informed that as part of the implementation of the Right Care Right Person[27], where a person is moved with consent, a digital voluntary handover form has since been introduced to be used when Officers transport individuals to Emergency Departments. This type of handover arises from 2014 civil caselaw in which a man sued the Metropolitan Police and St George's Hospital trust after, following police contact and a failure of supervision in an Emergency Department, his father left hospital and jumped from height, sustaining life altering injuries. The court ruled that the police had handed responsibility over to staff at the Emergency Department but recommended that a handover document should be used to convey information and to provide clarity in relation to who has responsibility for the patient.

Whilst not in place during the scoping period of this review, this review has further considered the 'Right Care Right Person' approach which aims to ensure that vulnerable people get the right support from the right emergency services. The approach involves the police working with partner agencies to identify the most appropriate agency to give vulnerable people the care and support they need.

[27] Right Care, Right Person is an approach designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs.

On the day that Hannah sadly died, the 'Right Care Right Person' approach would not have changed the response to Hannah hanging on to a high edge, as the threshold for a police response to a mental health-related incident is[28]:

- to investigate a crime that has occurred or is occurring; or
- to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm,

and Hannah was at immediate risk.

However, where there was no safety risk or crime, the new approach would have effected a change to the response, with the incident being referred to another partner agency as appropriate.

Throughout the scoping period of this review, Officers appropriately completed Vulnerable Person Referral Forms, which were on occasion forwarded to Adult Social Care. However, whilst this review doesn't doubt that individual Vulnerable Person Referral Forms were responded to and forwarded properly, it would respectfully question whether the sheer volume of forms should have triggered an escalated response, for example, by using the Multi-Agency Risk Assessment Management protocol.

Learning Points in relation to Merseyside Police:

- ***The volume of Vulnerable Person Referral Forms should have formed part of the risk assessment.***

Alcohol Support Services

Hannah was engaging with health and social care charity prior to the scoping period of this review. Her case notes evidence that at times, their engagement was successful but, sporadically would deteriorate. The decline in engagement would usually coincide with Hannah relapsing and drinking alcohol.

When Hannah had first engaged with health and social care charity a plan had been developed which included what the charity would do in the event of workers being unable to make contact with Hannah. And it had been agreed that her parents could be spoken too. It was positive practice that a recovery worker did speak with Hannah's family on occasions and that those conversations included how to treat alcohol withdrawals.

There were times during the scoping period of the review that Hannah was admitted into hospital for detox. On these occasions, this review has learned that it was Hannah who informed the charity of her admittance (and as a result, the charities liaison nurse would visit Hannah at whichever hospital she had been admitted into).

This practice has been discussed with the charity who highlighted how important contact with one of their service users is when they are undergoing a hospital detox in order to develop an action plan and discuss rehabilitation. This review learned however that the communication between the charity and hospitals doesn't always occur, and they wondered if a line of communication could be developed between them and hospital alcohol liaison nurses to establish whether individuals who are brought to the hospital's attention, are known to them. Currently the charity has a liaison nurse who is based at one of the hospitals in Sefton on a part time basis, and the nurse will often recognise an individual during the ward 'walkabout', but this window of opportunity is limited to the nurse's working hours and that hospital.

[28] National Partnership Agreement: Right Care, Right Person (RCRP) - GOV.UK (www.gov.uk)

In May 2023, due to a referral made by hospital 1's Alcohol Liaison Team, Hannah's alcohol support transferred to the Liverpool area and Hannah was closed to the health and social care charity. It is not clear whether Hannah requested this change or whether it was automatic due to her providing her father's address to the hospital. However, it is notable that it had only been a matter of days prior to this that Hannah had spoken to the charity liaison nurse in a frank and open manner – suggesting that a relationship was, or already had, developed. And therefore, it is questionable whether changing her support workers at this time could have affected an increase to her vulnerability and risk.

The charity advised this review that normally when a client transfers to another services, a transfer form is completed and there is an option for the services to speak to each other and have a conversation about the client. In Hannah's case the referral was made by hospital 1 and the charity wasn't aware of it until it was complete. By this time Hannah had started to receive support from the new provider which left the charity with no option but to close Hannah's case. This missed opportunity to transfer Hannah's information must have affected a 'start again' approach for Hannah. It is not known whether it was ever made clear to Hannah that if a referral was made to Liverpool Community Alcohol Services and Residential drug and alcohol rehabilitation service, her case with the charity would have to close.

Following the referral to Mersey Care NHS Foundation Trust Liverpool Community Alcohol Service, a Residential drug and alcohol rehabilitation Service detox worker attended Hannah in hospital and completed a referral to rehabilitation Service[29]. Hannah then started to attend the sessions at the recover hub support service and thereafter was welcomed into Residential drug and alcohol rehabilitation Service[30]. Residential drug and alcohol rehabilitation Service engaged Hannah effectively in therapy, relational recovery worker one-to-one sessions, and interpersonal group therapy and it was positive practice that in addition to alcohol support, Hannah was offered support for her eating disorder.

When Hannah shared that she continued to find the healing process difficult and had a constant urge to consume alcohol, it was positive practice that the team,

- provided increased welfare checks,
- offered a 'buddy',
- stayed with Hannah for observation/safety purposes, and
- the usual 18-week programme was extended to 22-weeks.
- It was after 12 weeks that Hannah relapsed and whilst not every relapse results in discharge, the decision was made to discharge her from Residential drug and alcohol rehabilitation Service as she had put the recovery of other residents in danger.
- Residential drug and alcohol rehabilitation Service has confirmed to this review that a member of their staff:
- informed Mersey Care NHS Foundation Trust of Hannah's discharge from their service
- submitted a safeguarding referral to Liverpool City Council as Hannah was 'missing',
- contacted Liverpool Housing Options,
- informed the police Hannah was missing via a 101 log, and
- made Homeless Outreach aware of the situation (however Outreach have no record of this contact).

There followed a period of Hannah leaving the premises and temporarily returning. On one occasion Hannah was taken to hospital by ambulance as she was experiencing seizures. Residential drug and

[29] The referral stated that Hannah had drank alcohol for 16 years and had used cocaine for 8.

alcohol rehabilitation Service kept the police and Careline[31] updated of Hannah's movements as best they could. Notably, once Hannah had been seen and was no longer classed as a 'missing person', Careline said that the matter was a police matter, but that they would put a referral into housing options on Hannah's behalf.

This review would highlight the positive care and practice exampled by the Residential drug and alcohol rehabilitation service and the Step Down[32] service with regard to the support that Hannah was offered. Professionals working within both services went above and beyond usual procedure when they continued to allow Hannah to return and - when it was clear that she was at risk of absconding, ensuring that Hannah knew that she could return to their service at any time via the recover hub support service. However, this review has been informed that Hannah's dad wasn't spoken to around the time Hannah relapsed. The service had Hannah's permission to speak with her dad, and it may have been useful to have contact with him at this time and to offer him advice with regard what to do if Hannah attended his address. For example, the outreach contact details could have been passed on to him.

The Independent Reviewer explored with a representative from the Residential drug and alcohol rehabilitation Service, whether consideration could have been had to convene a multi-agency meeting. Residential drug and alcohol rehabilitation Service confirmed that having submitted a safeguarding referral, their understanding is that Adult Social Care would have convened such a meeting if one had been deemed necessary – however conversations with Adult Social Care evidence that when the Residential drug and alcohol rehabilitation service informed them of Hannah having been seen safe, they deemed the risks to Hannah to have significantly decreased.

Learning Points in relation to Alcohol Support Services:

- ***There was an expectation from Residential drug and alcohol rehabilitation service that the communications they sent would be acted upon within the community.***

Homeless Services

The homeless charity has a hospital In Reach team which supports individuals who are ready for hospital discharge but have nowhere to live. The team works out of three hospitals but is predominantly based in hospital 1[33] (08:00 hours to 16:30 hours). This review learned that the In Reach team either refer individuals to Housing Options (who then assess whether the individual qualifies for temporary accommodation), or to their own Assessment and Referral services.

The hospitals alerted the In Reach team to Hannah on several occasions but because Hannah mostly presented at hospital out of hours, or would self-discharge before being seen, attempts made by the In Reach team to engage her were often unsuccessful. And when a worker did meet with Hannah face to face, Hannah (for reasons that this review is unable to now establish), was unable to engage with the support on offer and told the worker that she had been a rough sleeper but was returning to her father's address.

On another occasion the In Reach team managed to engage Hannah and referred her to Sefton Housing Options which was where Hannah's local connection was as per her previous address records. This review has learned that the In Reach team was not obliged to refer Hannah to Sefton, and that a referral could have been made to Liverpool Housing Options - it would then have been up to Liverpool

[31] Careline is a 24-7 contact centre for social care enquiries.

[32] Step Down offers post-treatment care and support to those who have successfully completed a period of rehabilitation.

[33] One staff member covers hospital 2, two days a week and another staff member covers the Women's Hospital as when required.

Housing Options to decide whether they could offer support, based on Hannah's circumstances. This was not done on this occasion, but it is possible that Hannah had requested the referral go to Sefton. Upon receipt of the referral, Sefton Housing Options sent a reference number to the homeless charity for their records, but no further contact was had between the charity and Sefton Housing Options. This review has learned that Hannah's referral was closed after a couple of months due to no contact attempts proving successful.

When Hannah presented as homeless out of hours, the hospital (or any professional/agency) could have given Hannah the telephone number for the charity's Outreach Service. This service is 24/7 and as it has access to a car, would have been able to attend Hannah and offer her support in real time. There is no record of Hannah ever contacting the Outreach Service, but this is not necessarily indicative of the contact details not being given to her, as it must be remembered that it is possible that Hannah would not have the means (telephone access) to contact the Outreach Service herself and/or that her mental health or substance use could have hindered her ability to make the contact.

A better option would have therefore been for the professional (either at the hospital, or any other agency) to contact the Outreach Service on Hannah's behalf. There is no record of this ever having been done which would suggest that greater awareness of this option is required.

Hannah did come to the attention of the Outreach Service on one occasion during the scoping period; members of the team came across her during one of their 'night-time walkabouts' of the city. Hannah was in an intoxicated state and became unwell whilst the team were with her. Consequently, an ambulance was called to take her to hospital.

It has been recognised that there was a missed opportunity at this time for the Outreach Service to email the hospital In Reach team to alert them to Hannah's presence at the hospital as they came on duty in the morning. However, it must be noted that it would appear that Hannah did not stay at the hospital for long, as she re-presented just before lunch and was brought to the attention of the In Reach team anyhow. Unfortunately, Hannah left before the team could engage her.

A representative from the homeless service has identified that there is a critical gap in the service by means of the In Reach team not being physically present at the hospital in the evenings and has informed this review that this gap will be fed back to management.

The homeless service has informed this review of some recent developments to their practice that have been implemented since the scoping period of this review to support out of hours referrals and multi-agency information sharing. They include: A daily referral sheet is now being sent from the homeless In Reach team to a core group of hospital staff every working day.

- Liverpool University Hospital Foundation Trust can now make an electronic referral to the In Reach team day or night, and out of hours, Liverpool University Hospital Foundation Trust can also now refer to the Liverpool Housing Options (Out of Hours Team).
- Contact cards are now available for hospital staff to pass to patients with helpful contact numbers.
- The In Reach Team is now meeting hospital 2 Mental Health team and Alcohol Team on a weekly basis, and meeting every month with Safeguarding, the Alcohol Team, the Drug services and Liverpool Social Services, to discuss more complex patients.
- The In Reach Team is meeting with hospital 2 on a monthly basis to discuss frequent attenders with Emergency Department staff, Police, and the North West Ambulance Service.
- The In Reach Team is meeting with the alcohol team at hospital 1 every week to discuss a list of patients that have presented.
- The In Reach Staff meet regularly with the Mental Health hub at hospital 1.

All of the above agency summaries, demonstrate how hard professionals worked to respond to Hannah in real-time and how they competently referred Hannah to other services for subsequent specialist assessment.

However it is also serves to highlight how agencies worked in silos and it is notable that, whilst Hannah was subject to some multi-disciplinary meetings, for example through the Liverpool University Hospital Foundation Trust frequent attenders meetings, the ambulance high intensity meeting, and an internal meeting at the health and social care charity; there was insufficient multi-agency risk assessment and action planning which could have been effected by means of the Multi-Agency Risk Assessment Management process.

Liverpool Safeguarding Adults Board have developed guidance[34] to support any professional from any agency to commence the Multi-Agency Risk Assessment and Management process. It has been updated since the scoping period of this review, but had the process been consulted in regard to Hannah, it would have been clear that Hannah's circumstances fit the criteria; as the guidance states that it should be used *in situations where there is concern that the individual's lifestyle or behaviour are likely to result in serious harm, or even death and single agency involvement has failed to be effective in the management of risk.*

The guidance further indicates that when Hannah was unable to accept support to minimise the risk, it would have been appropriate to call a Multi-Agency Risk Assessment Management Meeting and share Hannah's information multi-agency.

The Multi-Agency Risk Assessment Management Meeting process would have been a better process to follow than the aforementioned Complex Lives, because Complex Lives is a meeting forum at which multiple individuals are discussed. The Multi-Agency Risk Assessment Management Meeting is convened to discuss a specific individual and offers continuity as it will re-convene to assess the action plan and update.

Multi-Agency Learning Point:

- ***Hannah's support offer needed the continuity and the central lead that the Multi-Agency Risk Assessment Management process would have offered.***

What are the barriers professionals face with regards to achieving engagement, good practice and utilising all the relevant pathways?

Though there are similarities to previous Safeguarding Adults Reviews commissioned by Liverpool Safeguarding Adults Board (SAR Paul & James, and SAR Colin), it is clear from the conversations had with professionals who were working to support Hannah, that Hannah's case does differ; as professionals working to support Hannah did achieve an element of engagement, and some had started to build the foundations of a relationship with her. However, this 'element of engagement' potentially then contributed to professionals not embarking processes such as the Multi-Agency Risk Assessment Management. This was because when professionals were able to engage Hannah and she was sober, she indicated a desire to get better, a knowledge of what she needed to do, and an understanding of who could support her. Hannah also for a period of time, executed what she had to, in order to secure a place at the rehabilitation centre. This instilled a sense of positivity and optimism in professionals which effected a reduced risk of harm. Even post rehabilitation, when concerns for Hannah were high, Hannah continued to reach for support when in crisis and demonstrated (at least to the GP) a desire to return to rehabilitation. Professionals' risk assessments were being based on how Hannah presented on that day, at that time; but consideration needed to be had of how many times Hannah was presenting, how many times Hannah was 'saying the right things' and what was actually changing for Hannah. Consideration of this bigger picture would have helped professionals

[34] MARAM-Process-FINAL.pdf (lccdigitaloce.com)

to recognise that multi-agency discussion and action planning was needed – which in the absence of safeguarding thresholds being met, the Multi-Agency Risk Assessment Management process could have achieved. However, it cannot be ignored that as previously mentioned, there are still professionals who are unaware of the Multi-Agency Risk Assessment Management process and therefore, are unable to consider it. Amongst those who are aware of Multi-Agency Risk Assessment Management, there is an element of confusion in regard to the process; in particular because the process does not commence with a referral. It is a policy for professionals to follow and whilst it is recorded on Liquid logic, there is no specific agency who oversees the process.

Multi-Agency Learning Point:

- ***Risk assessment needed to be holistic and not just based on Hannah's presentation at that time.***
- ***Some professionals remain unaware and/or don't understand the Multi-Agency Risk Assessment Management process***

Further confusion was identified by the professionals who attended the learning event, in relation to the different umbrella terms for meetings. They asked for clarification of the differences between a multi-disciplinary meeting, a multi-agency meeting, a strategy meeting, a Multi-Agency Risk Assessment Management meeting etc.

Multi-Agency Learning Point:

- ***Multi-agency meetings terms/names need clarification.***

It is positive that on one occasion, hospital 1 recognised Hannah's self-neglect and submitted a safeguarding concern[35], but self-neglect was mostly overlooked (even though Hannah's circumstances fit Liverpool Safeguarding Adults Board description of self-neglect on their website which is a *lack of self-care, lack of care for one's environment, and/or the refusal of services, to an extent that it threatens personal health and safety[36])*. This effected the sustained single-agency response and contributed to a lack of multi-agency work which gave Residential drug and alcohol rehabilitation service to no single agency ever developing a complete overview or full understanding of Hannah's circumstances.

In relation to thresholds (for example, self-neglect and safeguarding) the professionals supporting Hannah have recognised that they worked their decisions in silos, and that without the input of the other agencies, the single agency silos picture of Hannah's circumstances mostly concluded that she didn't meet thresholds. As mentioned, rationale offered to this review has included the fact that Hannah agreed to referrals being made to support services, but a lack of safeguarding consideration can also be somewhat attributed to the fact that Hannah's alcohol addiction dominated action and support plans, and as such, it was considered that if the addiction was addressed – the rest of the

[35] This concern did not progress to an investigation at this time as Hannah was going into rehabilitation.

[36] The website further explains that self-neglect includes

- A lack of self-care to an extent that it threatens personal health and safety
- neglecting to care for one's personal hygiene, health or surroundings
- an inability to avoid self-harm
- a failure to seek help or access services to meet health and social care needs and/or
- an inability or unwillingness to manage one's personal affairs

concerns would automatically be addressed. Importantly, the absence of any professional convening and leading on any multi-agency meeting to help develop multi-agency understanding and planning around all of Hannah's circumstances, i.e., her alcohol use, mental health, homelessness etc, would suggest that not all professionals understand that they do not need to wait for the section 42 threshold to be reached before convening a multi-agency meeting.

Multi-Agency Learning Point:

- ***Professional responses to Hannah's circumstances were often single agency attempts to address a presenting concern rather than a multi-agency co-ordinated response which would seek to understand and address all of the underlying drivers.***

The Liverpool Neighbourhood Model divides the city into 12 locality teams. This has been identified by professionals involved with this review, as creating a barrier to practice because there is increased complexity in service provision when it has to occur across local authority borders. For example, difficulties can arise where commissioning responsibilities are held by one neighbourhood but concerns about potential abuse or neglect arise in another. Indeed, this review learned that had the incident that Hannah was victim to, been submitted as a safeguarding concern, the local authority for the area where the abuse had occurred would have had the responsibility to carry out the duties under Section 42 of the Care Act 2014. Yet Hannah's placing local authority would continue to hold responsibility for her commissioning and funding.

Furthermore, if a professional wants to make a referral for services to support an adult, they must first identify the correct local authority for the adult in question. With so many local authorities, the chances of an individual presenting at a hospital Emergency Department outside of their own local authority is high, and professionals identified that because their departments are so busy, they don't always have the time to safely work out which local authority is the correct to refer to. Consequently, there is a real risk that referrals are being generated to the wrong areas, and this will serve to effect delays which in turn increase the risk to the individual.

Professionals agreed that ideally, a central portal is required for all of the boroughs.

Significant to this review is that professionals who have been involved, have demonstrated a good awareness of Hannah's vulnerabilities and there has not been any suggestion of professional *desensitisation* to Hannah's circumstances. Discussions have identified more of a *frustration* in regard to how to support an individual who repeatedly proves unable to be engaged with the long term support offer. This frustration is potentially indicative of a poor understanding of the complexity and power of addiction - a disease that changes the brain and how it functions.

The continuing issue was that when Hannah drank alcohol, whilst she remained able to seek some crisis support, her ability to be engaged with long term support would withdraw. Any intention Hannah had when she was sober to access support would disappear when she drank alcohol, and Hannah, as an individual who was living with an addiction, was unable to stop drinking.

Hannah would not have chosen to be sick in Emergency Departments, abusive to professionals, lose her job, cause her family worry, hurt the people she loved, or hurt herself. Her behaviour was underpinned by the addiction yet generally; her addiction was seen as 'behaviour'. Professionals need to remember to keep looking beyond the behaviour and at the addiction.

As an individual addicted to high consumption of alcohol, the level of engagement that was required with Hannah to achieve an effective support plan was outside of her capability. This meant that when

the crisis driven support services made the referrals into longer term interventions such as alcohol services and mental health support, in the long term they proved ineffective. There is nothing to evidence that other approaches were considered but when this was discussed with professionals their responses outlined a lack of known alternatives.

What are the family's views

The Independent Reviewer had hoped to integrate the family's voices into this review by utilising the information they had previously provided to the Mersey Care NHS Foundation Trust Safety Incident Response Framework - but regrettably, as previously mentioned, the report has not been made available for the Independent Reviewer to consult before the final draft of this document was agreed upon. Consequently, this Safeguarding Adults Review has only been able to incorporate the family's perspectives as recorded in agency case notes, and their views have not been independently verified. This has left this Key Line of Enquiry unanswerable.

4. Conclusions and questions for Liverpool Safeguarding Adults Board and its Partner Agencies.

The lessons learned from this Safeguarding Adults Review commissioned by Liverpool Safeguarding Adults Board are highlighted in bold text throughout this report, but to conclude:

- Hannah lived with an addiction and poor mental health – this comorbidity is complex and is sadly reflective of other individuals' lives and has been subject of previous Safeguarding Adults Reviews commissioned by Liverpool Safeguarding Adults Board. As such, the improvement plan developed for this review should be measured against other recently established improvement plans to avoid unnecessary duplication.
- However, Hannah's circumstances are different because professionals were able to achieve an element of engagement with her. Hannah (when not intoxicated) was a well presented, articulate and intelligent young lady. She evidenced a good understanding of her problems and an ability to seek support. However her addiction and mental health affected her ability to be engaged long term and to maintain improvements.
- During the times when Hannah presented well and was seeking support, professional risk assessment was based upon her current presentation. Her holistic and long-term ability to be engaged, and her increased vulnerabilities when intoxicated, were overlooked.
- Consequently, safeguarding referrals were sometimes missed and/or thresholds deemed to not have been met. And because some professionals were either:
- further confused by the multiple terms used in relation to multi-agency meetings,
- unaware of the Multi-Agency Risk Assessment Management process, or
- unsure of the Multi-Agency Risk Assessment Management process
- agencies continued to make the appropriate onward referrals to other services, but risk assess and action plan in silos.
- Inevitably, Hannah would eventually present to professionals in crisis and with contrasting demeanour and behaviours - owing to intoxication and mental health. On such occasions, Hannah could be violent and opposing. At such times Hannah was increasingly vulnerable, and it was a challenge for professionals to safeguard her.
- Once the crisis had passed, Hannah would regain her understanding of her circumstances and seek support, instilling professionals with an element of optimism once again.

- Some of the lessons learned during the process of this review have already been recognised and started to be addressed, either by single-agency or multi-agency developments to practice. These have been described within the body of this report.
- Other lessons learned will be addressed by means of the improvement plans that are being developed in response to other Safeguarding Adults Reviews.
- To address the outstanding lessons learned from this Safeguarding Adults Review, the Independent Reviewer would ask Liverpool Safeguarding Adults Board and its partner agencies to deliberate the following questions and use the ensuing debate to develop an improvement plan for future practice in order to support the safeguarding of individuals like Hannah in the future.

1. ***How can Liverpool Safeguarding Adults Board promote the revised guidance on how to identify and respond to adult safeguarding concerns and how can its effectiveness in practice thereafter be evidenced?***
2. ***How can Liverpool Safeguarding Adults Board support its partner agencies to promote the Multi-Agency Risk Assessment and Management process to their staff and ensure that all professionals understand their responsibility to lead on the process where appropriate.***
3. ***How can Liverpool Safeguarding Adults Board engage and educate agencies in the private and voluntary sectors (such as*** **Residential drug and alcohol rehabilitation service*****) of their multi-agency safeguarding processes (including the Multi-Agency Risk Assessment Management Protocol)?***
4. ***Who can review safeguarding concern forms to ensure that concerns are being recorded in their own right and feedback the findings and subsequent action plan to Liverpool Safeguarding Adults Board?***
5. ***How can Liverpool Safeguarding Adults Board ensure that the Improvement Plans for this review take the plans from previous Safeguarding Adults Reviews that haven't been implemented at the time of writing this report, into consideration?***
6. ***How can Liverpool Safeguarding Adults Board support professionals from all agencies and organisations to understand the different terms/names for multi-agency meetings.***

5. Appendix 1

This Safeguarding Adults Review will reflect on multi-agency work systemically. Importantly it will recognise good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements.
In order to achieve the specific request of Liverpool Safeguarding Adults Board to undertake this review with a greater focus on practitioner engagement, and limited panel involvement, the review will take a specific approach which will focus on engagement with key identified frontline practitioners and their managers via 1:1 discussion with the Independent Reviewer, and a wider practitioner learning event that will look at why those involved acted in a certain way, at that time.

The report will also draw from previous Safeguarding Adults Reviews commissioned by Liverpool Safeguarding Adults Board and will highlight any similarities within their learning and consider the impact of their ongoing action plans.

6. Appendix 2

The Review Panel Members

- Independent Reviewer
- Board Manager, Liverpool Safeguarding Adults Board

A representative from:

- Merseyside Police
- Liverpool Adult Social Care
- Integrated Care Board- Liverpool Place
- Mersey Care NHS Foundation Trust
- Liverpool University Hospital Foundation Trust
- Residential drug and alcohol rehabilitation Service
- North West Ambulance Services

7. Appendix 3

Areas identified during scoping for consideration within enquiries:

- Safeguarding/ Care Act Assessment/ Care Act Eligibility/ S42 referrals
- Alcohol Services/ Detox Provision
- Professional Understanding of the Mental Capacity Act / Executive Functioning / the Mental Health Act / Statutory Legislation and Duty of Care – including Professional Desensitisation
- Complex presentation and how professionals can be supported to remain focussed on the person
- Explore any Missed Opportunities (including any professional neglect through active omission)
- Professional Application of Professional Curiosity.
- Multi-Agency Risk Management
- Self-neglect/ Unmet care needs
- Hidden Homelessness
- Dual diagnosis
- Discharge planning / risk management / supervision
- GP Practice Management
- ACEs / transitional care / Education / Lived Experience
- Consultation with historic records – trauma informed practice
- Employment

8. Appendix 4

Practitioner Learning Event

A learning event was held and attended by representatives from:

- Liverpool University Foundation trust
- Hospital Emergency Departments at hospital 1 and 2
- Merseyside Police

- North West Ambulance Service
- The AMP Service
- Liverpool City Council Adult Social Care
- GP Practice 2
- Residential drug and alcohol rehabilitation service
- Health and social care charity’
- Homeless Services
- Mental Health Liaison Teams from hospital 1 and 2