Safeguarding Adults Review for

JAMES

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Trafford SAB

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1. Executive Summary

1.1 Background and context for the review

The Trafford Safeguarding Adults Board (SAB) commissioned this Safeguarding Adults Review (SAR) in Spring 2025 to understand the care and support provided to an adult man who was living with complex vulnerabilities and who was known to several Trafford district services, along with services provided by neighbouring districts of Greater Manchester and Cheshire, including various hospitals.

The adult man at the centre of the review process is called James for the purposes of this review. Very sadly James died in early November 2024. The medical cause of his death was an insulin overdose. A Coroner's Inquiry into James's death will further investigate the wider possible causes and circumstances of his death.

Shortly after his death, a SAR referral was made by Greater Manchester Police (GMP) due to concerns that James's death may have been linked to self-neglect, primarily associated with his alcohol use, diabetes and homelessness. There was also a reference to the context of bi-lateral domestic abuse associated with James and members of his family members, which suggested further vulnerability. This SAR referral was initially screened by a multi-agency panel in November 2024 but requested more information from agencies to make a final decision. In February 2025, agreement was reached by the agencies that submitted information for consideration that the SAR criteria had been met.

The screening decision highlighted that a Section 42 safeguarding enquiry was underway at the time of James's death but had not concluded. A full mental capacity assessment had also commenced but required further contact with James before a final assessment could be made. Despite multiple agencies being in direct contact with James and him being identified in numerous multi-agency conversations about high-risk domestic abuse (in Multi-Agency Risk Assessment Conferences (MARAC)) the screening decision identified concerns that key information about the full complexity of James's care and support needs had not been collectively recognised, particularly the specific health and wellbeing risks associated with his self-neglect. Alongside this, it was noted that there were missed opportunities to initiate an earlier statutory assessment and safeguarding response to address James's multiple support needs and involve all relevant agencies in this process. These considerations resulted in this SAR being commissioned.

Contextual information relating to providing services to adults where their care and support needs cross or move between geographic or administrative boundaries

Part of the remit of the review is to understand if improved communication and co-ordination between agencies and services may have led to better and earlier support for James at a time of his life when he appeared to be in deep crisis. One of the

features this review contemplates is the cross-boundary aspects of his care and support.

It is not uncommon for adults who are homeless to arrive in a district where they have no recent history of using services and their health and care history is not known, other than through self or family disclosures. This was initially the case for James and although he did register with a Trafford GP in February 2024 (from Cheshire where he had previously lived) and started to use local health and care services, substantially from December 2023, the level of his care and support needs and vulnerability was not well-understood at the time. In fact, there appears to have been relatively limited multi-agency collaboration until July 2024 when the concerns about James were escalated to a Section 42 safeguarding enquiry.

The review heard that it is not common practice for vulnerable adults to be 'flagged' on electronic GP systems in the same way that a vulnerable child would be, when moving between different districts for instance, to support safeguarding. Outside of GP health records, the general feedback from services involved in the review is that there are no automatic or proactive protocols for sharing information about a vulnerable adult across different geographic / administrative boundaries. However, several organisations do work across different geographies and in that case can see an individual's contact with them in different areas or settings i.e. GMP cover all 10 Greater Manchester Policing districts, the Greater Manchester Mental Health Trust (GMMH) serves people across several districts of Greater Manchester and Manchester University Hospital Foundation Trust (MFT) can share patient information across its hospital sites through its information-management system HIVE.

This means that the individual practitioner, at their discretion, would have to proactively contact services in a different district to understand the adult's history (if the adult did not provide this themselves) - which could in theory also be subject to UK GDPR data protection conventions and the consent of the adult. Homelessness services did this informally with their equivalent service in Cheshire East. One of the acknowledged learning points for Trafford Adult Social Care is that it would have been good practice to contact Adult Social Care colleagues in Cheshire East to understand if James had been known to them and on what basis.

In addition, adults who are homeless may be housed in emergency temporary accommodation that may not be in the same district as they present as homeless, or in the same district where they are registered with a GP for example. Because of the way health and care services are funded and administered, this can present challenges to delivering services in a co-ordinated way. For example, at one point James appears to be placed in emergency accommodation in Manchester, but in conversations with agencies it was acknowledged that arranging healthcare support for James e.g. a Trafford GP requesting District Nursing at a Manchester address would have been an exceptional arrangement and was therefore not provided. However, re-referral between District Nursing Teams is a possible solution to this.

JAMES's family, social and health context

The complexity of James's life experiences alongside his health, care and social needs are important context for the review.

James had a complex family history. Records note that he disclosed having a very difficult childhood with sustained exposure to domestic abuse perpetrated by his father against his mother and James himself. His father was an alcoholic and died of alcohol-related organ failure.

James is noted as disclosing that it was his father's death that triggered his use of drugs and alcohol from around the age of 19. Although James's alcohol use appears to have been long-standing, his family reported that it increased following the deaths of 3 close family members which happened around 4-5 years prior to James passing away. A breakdown in the relationship with his partner, whom he had lived with in Cheshire, seems to have immediately preceded the time period this review is considering and his family felt that he had become depressed following the split and especially in the final 6 months of his life.

Another aspect of his recent family history are relatively frequent reports of domestic abuse between James, his mother and his sister.

James also had complex health and social needs, although not all these issues were recognised by services at the time. His contact with mental health services appears to go back over 20 years, with psychological therapies, community mental health services, mental health crisis support services, substance misuse services and numerous contacts with mental health liaison services whilst attending hospital Accident and Emergency (ED) departments. Case records from mental health services show that JAMES had a history of suicidal ideation and it was reported by JAMES himself in case notes from 2012 that he had previously initiated several non-fatal suicide attempts. He had also reportedly taken an intentional overdose of insulin (prescribed for the management of his diabetes) when presenting at a hospital in November 2022. There is a suggestion of James tending to have 'impulsive' suicidal behaviour, perhaps as a response to issues or feelings that he found too difficult to deal with in the moment.

Alongside his alcohol use, James lived with a form of insulin dependent diabetes, called Type 3c diabetes. This means that JAMES had to regularly monitor his blood glucose levels and administer insulin to himself. His family indicated that this condition was diagnosed by Macclesfield hospital around 10+ years prior. Type 3c diabetes is a form of diabetes resulting from damage to the pancreas, which can affect blood sugar regulation and digestion. It is commonly, but not exclusively, seen in adults who are alcohol dependent, as long-term alcohol use damages the pancreas causing chronic pancreatitis. One of James's first admissions to a hospital in Greater Manchester in mid-December 2023 was based on him suffering with acute pancreatitis. It seems that his family and his previous partner provided James with a lot of support to manage his diabetes, including helping to monitor his blood glucose

levels and safely keep and administer his insulin. One of the complexities that this review must consider is how it was possible for James to safely administer insulin to himself whilst intoxicated and whether the risk arising from James unintentionally or deliberately overdosing on insulin was understood, mitigated or clinically monitored by relevant services.

SAR timeframe and focus

This review scope covers around a 1-year period prior to James's death, from November 2023 up to November 2024 when he passed away. The beginning of this period is around the time when James became permanently resident in Trafford and was actively seeking temporary accommodation there. Other relevant contextual information has been provided by a range of agencies to help understand the broader circumstances of James's life and history and the extent of any previous contact with services in Trafford. The review has considered James's relationships, his housing arrangements, contact with different services and his complex health, care and support needs.

Although James began to access health services from the time he started to reside in Trafford, this intensified considerably from January 2024. The focal point for the review is the period January – November 2024 when James became repeatedly visible to multiple services in Trafford. Over this period, James's attendance at hospital accident and emergency departments was exceptionally high, although he typically presented at one particular hospital emergency department (ED). It wasn't unusual for him to present 2-3 times across a 24-hour period. From 1 January to the end of February 2024 he attended the same hospital on at least 16 separate occasions, sometimes with an ambulance crew, sometimes self-presenting. It was at the beginning of February, that James was first referred from ED into other services, including the Trafford homelessness team and specialist community support for his substance dependency.

The findings and learning from this SAR are particularly relevant to services involved in supporting adults who:

- need to access emergency homelessness accommodation and are living with complex health and social care needs
- are both alcohol dependent and insulin dependent and need to consider how to manage and mitigate the perhaps inevitable risks for such adults of medical self-neglect - and/or intentional suicidality where this is part of the adult's pattern of behaviour

The review may also be of interest and contain relevant insight for any services that encounter or are working directly with adults who experience complex and intersecting vulnerabilities, including multiple physical health and care needs, alcohol dependency, homelessness or housing insecurity, suicidal ideation and domestic abuse.

1.2 The review process

The review process was based around a relatively typical methodology for a SAR consulting widely with family, practitioners, service leads and an oversight panel of representatives from many of the agencies involved in James's care and support. The SAR was conducted over an approximately 5-month period between April – August 2025 and consisted of the following elements:

- Provision of a case chronology which documents the contacts with James and summary case notes from relevant agencies over a roughly 1 year period prior to his death, from which the independent reviewer developed key lines of enquiry (KLOE) as the basis and focus for the review
- An initial multi-agency panel meeting to agree/adapt the KLOE and the review process
- Individual agency meetings and record checks to discuss the KLOE.
- Several follow-up meetings and clarifications with agencies/services who could offer specific expert or alternative perspectives on James's health conditions or family circumstances
- A multi-agency Practitioner Event where colleagues who had worked with James were able to discuss their experiences of supporting him, along with other agencies or services who wished to participate in and learn from the review process
- An invitation to two close family members to contribute to the review. One family member spoke to the reviewer in relation to James and their experiences with him particularly in the year before his death. This same person also spoke on behalf of another close family member with their agreement
- Production of an initial analysis report, discussed at a multi-professional SAR Panel meeting
- Production of a final analysis report with recommendations for comment by the SAR Panel, followed by discussion at the Safeguarding Executive

An important aim of the review process is to understand who James was and what he wanted, through the eyes of those who knew him well and the practitioners that worked with him.

James's family said that James was an emotional and sensitive person, and he was particularly affected by the loss of 3 close family members in the previous 4-5 years before he died. His family gave examples that suggested James had been emotionally and physically bullied as an adult and this, along with his alcohol dependency and health issues, made him vulnerable to being taken advantage of. His family reported that he had been bullied in temporary homeless accommodation settings and felt that this type of accommodation was generally unsuitable for James

because of the level of support he required to manage his diabetes and other risks such as seizures.

Jamess' family believed that he had a strong desire to reduce his drinking and said that he was sometimes frustrated by advice given by health and specialist substance dependency services not to reduce his drinking unsupervised, because of a high risk of seizures and destabilising his other health conditions. It should be said that this professional advice was in line with general clinical guidance for an adult living with alcohol dependency.

Practitioners said that James was generally a polite and personable man. However, due to his use of alcohol, the way he presented from contact to contact could vary significantly, along with his capacity to benefit from some of the support that was available to him. One example of this is James's tendency to abscond from hospital or self-discharge before he had been assessed or completed treatment. The chronology shows numerous occasions where the Police had been asked to find and persuade James back to the hospital, so that he could receive the care he needed. Practitioners said that when James was more stable and his alcohol use was under a degree of control, it was easier to engage him meaningfully and at these times he had expressed feelings of guilt and a sense of failure about his drinking.

The overall sense from practitioners is that it was very challenging to work with James consistently and make progress. This was also partly attributed to his high number of hospitalisations, which practitioners were not always aware of, and which appeared to contribute to the fragmented care and support that James received. One practitioner felt that James required professional support at a level of intensity that exceeded typical practice norms and the homelessness team observed that James experienced a level of vulnerability that they characterised as severe.

James's family made a similar observation about the impact James's alcohol use had on his behaviour, for example, when under the influence of alcohol James could make allegations to the Police against family members e.g. of theft, domestic abuse. However, when he had slept and recovered, he could not remember that he had made the allegations, apologised to his family and withdrew the complaint.

1.3 Overview of the case and care scenario

Although the review has not been able to pinpoint exactly when James moved permanently into Trafford, it would seem to be around October 2023. However, prior to that James appears to have spent an estimated period of 3 months in Trafford probably living with a family member (September – November 2022), based on records from the Police, ASC and the mental health liaison services (mental health support/assessment provided when an individual presents at ED in crisis).

From October 2023 until James sadly passed away in November 2024, he very frequently attended a particular hospital emergency department (ED) in crisis, from

where he was referred into other support services. Because there are too many separate events to summarise here, this overview captures the overall pattern of James's reasons for attending hospital, any notable events and the response from services on a broadly month-by-month basis. It was common for suicidal ideation to be the primary reason for his attendance, alongside concerns about his physical and diabetes symptoms, including low blood sugar, insulin overdose, and intoxication. On occasion, James alleged or discussed domestic abuse by family members whilst in ED, which resulted in referrals to the Trafford Domestic Abuse Service on several occasions. This pattern characterises the main reasons that James attended hospital throughout the year before his death.

The other main route to James becoming known to services during this period, which was running in parallel to his contact with health and care services, was his referral into the MARAC process due to the bi-lateral domestic abuse that was reported between him, his mother and sister. James was first referred on 21 February 2024 following an incident where he was identified as a victim of domestic abuse. Across the review period, there were 4 MARAC meetings where James's circumstances were heard, two in March, then May and September 2024. Notes suggest that actions were set for several different agencies following these meetings, including Adult Social Care, the hospital safeguarding team, the Police and the community mental health team (CMHT). James was reported to be both a victim and perpetrator of domestic abuse across these meetings.

During November and early December James made 3 visits to different hospital emergency departments around Greater Manchester. On 7 December, the Police were called to James's sister's address due to a domestic disturbance. At this point James was said to be homeless by his sister. 3 days later, on 10 December he presented to a Manchester Foundation Trust (MFT) hospital ED in crisis following a paracetamol overdose and he was admitted due to chronic pancreatitis.

He remained in hospital until late December 2023 and at this time, discharge arrangements seemed to depend on James finding temporary accommodation. The Trafford homelessness service tried to facilitate this, but it was noted that James did not engage with the process but the detail of this is not documented. This resulted in him being discharged on 28 December with advice to contact Macclesfield homelessness services.

During January 2024, James attended the same hospital ED on numerous occasions. On several of the hospital attendances in January, James was assessed by the Mental Health Liaison Team but he was always assumed to have mental capacity, as required in the Mental Capacity Act code of practice. On 23 January James's sister supported him to attend an appointment to discuss his homelessness.

From early February, the substance misuse outreach service became involved with James and it appears that residential treatment options to support him with alcohol

abstinence were being discussed, however progress required evidence of abstinence by James.

A similar pattern of hospital attendance continued during February and March, with James acknowledging several insulins overdoses during this period, often whilst intoxicated, and he later expressed regret about what had happened. He is noted to have said that he wasn't able to cope at the temporary hotel accommodation which is why he kept returning to his sister's and mother's addresses.

From the middle of March 2024, although James's pattern of attending hospital emergency departments in crisis was largely consistent, the services that encountered him appeared to become increasingly concerned and this resulted in 3 safeguarding alerts being separately raised by 3 different services during March. In late March Trafford homelessness service also e-mailed Trafford Adult Social Care (ASC) and the local substance dependency service expressing concerns about James's capacity to cope and repeated presentations to hospital in crisis. His sister also reached out to the GP and a mental health service helpline for support on James's behalf during March and April.

On 2 and 19 April two safeguarding concerns were raised by the Manchester Foundation Trust hospital ED that James regularly attended. The first was in relation to family care dynamics as James had reported that his family was withholding his medication. The second was in relation to self-neglect and substance misuse.

At the end of April, in what appears to be a response to a referral from the hospital ED, James was contacted by the Community Mental Health Team (CMHT). This resulted in initial telephone contact where it was noted that James was confused and he disclosed that he had dementia. The intention had been to follow-up with a face-to-face assessment, but GP case notes later document that the referral to mental health services had been rejected due to James's alcohol dependency.

On 2 May, the substance dependency outreach worker e-mailed Trafford ASC with concerns about James's "self-neglect leading to life threatening issues". The response from ASC to this concern and the previous concern raised by the homelessness team was that James had been assessed in April 2024 and did not have eligible care and support needs under the Care Act 2014 and was therefore not open to ASC. The stated view was that James's needs related to his alcohol dependency and insulin management. Case notes suggest that James's GP had been asked to make a referral for James's insulin to be 'reviewed'.

On 7 May James attended ED with seizures having tried to stop drinking abruptly. The hospital alcohol team gave him advice and it was confirmed that alcohol detox / rehabilitation options were being sought for James. To support his sobriety and provide support over the weekend, he was admitted to hospital for several days, but it is noted that he was unwilling to stay in hospital to allow his insulin dosage to be reviewed and he self-discharged against medical advice after 7 days.

A few days later, James represented at the same ED. At this visit a safeguarding concern was raised by the hospital due to reported evidence of significant self-neglect and inability to self-care whilst James was staying at temporary hotel accommodation. He had been found incapacitated with low blood sugar in a suspected diabetic coma. Despite this, when James recovered, he again self-discharged against medical advice. Around these incidents, there appears to be an increased level of communication between the hospital alcohol team and the community alcohol workers with discussions around the need for a multi-disciplinary professionals meeting (MDT) to be called with involvement from clinical/healthcare professionals.

In early June James's sister mentioned her concern to the community alcohol team that James's alcohol use had increased and he had become involved in a relationship with a woman whilst staying at the temporary homeless accommodation and she had concerns about James being financially abused and being provided with alcohol. This resulted in another safeguarding concern being raised by the community alcohol team, followed by an attempt to arrange a professionals meeting with the GP. On 14 June, a telephone conversation between the community alcohol team and the GP took place where there was agreement about the need to step up the safeguarding response surrounding James. It seems that the GP then re-contacted the Trafford ASC safeguarding team directly, encouraging the use of a safeguarding MDT.

In the meantime, James continued to attend ED across June. On one of these occasions on 8 June he experienced auditory and visual hallucinations and is recorded as being acutely confused and disorientated. Although James initially absconded from the department, he was returned via ambulance and the Acute Medical Unit sought a DOLS (Deprivation of Liberty Safeguard), due to the concerns around his presentation and capacity. In the following days he underwent an MRI brain scan, which was recorded as showing generalised brain atrophy that was noted to be quite prominent for his age. His sister attended the hospital and confirmed that James's memory had been noticeably deteriorating for the past 8 months. Despite these concerns, James self-discharged a day later without a formal capacity assessment having taken place, although it was recorded that James was considered to have capacity at the time he left the department. It is not clear if the DOLS application was formally revoked.

On 29 June, the hospital ED made another safeguarding referral in relation to James. On 2 July a formal s42 safeguarding enquiry was opened by Trafford ASC.

From this point, initial conversations with other professionals lead to the first of four safeguarding multi-disciplinary professionals' meetings (MDTs) in July. A full discussion around James's situation appeared to take place and several actions were agreed including a referral into RADAR (rapid transfer from hospital for alcohol detox), a referral to the diabetes team for support with the management of diabetes and insulin medication, ongoing assessment and support from the community

alcohol specialist team, Care Act Assessment by ASC, and ongoing accommodation to be provided by the homelessness team.

Following this meeting the MARAC (high risk domestic abuse) process seemed to connect with the s42 safeguarding enquiry. There were 3 further safeguarding strategy meetings across October 2024. Concerns around James's capacity and his ability to understand harm reduction advice and retain information to keep himself safe were the focus. Homelessness colleagues also advised that James's needs were too complex to be managed in an emergency homelessness setting, which began a process of looking for alternative specialist accommodation for James outside of Trafford. On 2 October, a formal Mental Capacity Assessment for James was commenced by the social worker leading the safeguarding enquiry. Also present at this home visit was the practitioner from the community alcohol team. The third strategy meeting on 10 October focused on the need for a dementia assessment for James and alcohol rehabilitation and supported accommodation options. The fourth strategy meeting took place on 23 October whilst James was still admitted to hospital, and he appeared to have a successful in-patient detox during this admission at a different hospital in Manchester. Accommodation options to support his discharge from hospital were discussed and a referral into the hospital diabetic team was requested.

It is understood that on James's discharge from this MFT (Manchester) hospital in late October, a few days before his death, there appear to have been concerns about James's ability to administer insulin himself, as a referral into the District Nursing service was made at the point of discharge, which James consented to. It is not known what happened to this referral, or if it had been possible to contact James for example.

Shortly after this discharge, James experienced a fall due to intoxication and represented at ED, however, he was discharged to his mother's address. In the days that followed, James had several contacts with the Police due to alleged domestic abuse incidents. He also received a joint face to face visit from the specialist community alcohol workers where a detailed discussion with James happened, covering his alcohol use and potential treatment options. The case note of this visit suggests that James was experiencing a degree of steadiness in his alcohol use and he reported that his diabetes was also stable. He said that he was not experiencing suicidal thoughts.

Following this visit, on 4 November, James was transported by ambulance to another Greater Manchester hospital (Northern Care Alliance NHS Foundation Trust) following a collapse associated with low blood sugar. He was admitted for several days and discharged once stabilised on 7 November. James was reviewed by the specialist diabetic nurse on this short stay in hospital. On the following day, reports of concern for James were made by the temporary accommodation where he was staying, after a call from his family. An ambulance was called and sadly he was found to have died by ambulance colleagues.

1.4 The key issues under consideration

Initial key lines of enquiry (KLOEs) were developed by the independent reviewer based around the chronology and were then discussed with the SAR Panel. The KLOEs were used across the review to explore with agencies and practitioners how James's care, support and housing needs were assessed, delivered and co-ordinated. Because James lived with multiple issues that contributed to his vulnerability, the KLOEs also investigate how well the risk of harm to James was understood by practitioners and whether the actions taken to safeguard him were appropriate and proportionate to these risks.

These were:

1. What cross-borough protocols are in place to share information about a vulnerable adult when they present from another borough / at a hospital emergency department?
2. When an adult is open to multiple agencies/processes at the same time, how is support usually co-ordinated in Trafford?
3. Was the Trafford multi-agency risk management (MARM) process considered as a way of managing James's complex circumstances?
4. How should/could James's exceptionally high use of hospital emergency departments been robustly flagged as a significant and ongoing safeguarding concern?
5. In your review of this case, are you satisfied that colleagues working with James had a holistic view of his vulnerabilities and were theoretically able to form a view on risk of harm?
6. Where adults are considered vulnerable and at risk of harming themselves, what are Trafford's / your agency policies and practices around managing/addressing suicide risk?
7. When were James's memory issues recognised by services?
8. Why were residential rehabilitation provision or specialist supported housing not considered for James until a few months before this death?
9. What do you believe should have been an appropriate response to the risks around James self-administering insulin whilst intoxicated, including the numerous instances where he was observed by professionals doing this?
10. Would you say there was confusion about who should advise / address the concerns around James's type 3c diabetes and his use of insulin?
11. What alternative clinical protocols are available for diabetes management? i.e. to protect someone who lacks capacity to self-administer life-saving medication, which if administered incorrectly could also endanger their life

12. What are your thoughts on the approach taken by services to engage James's family?
13. Was the rationale for decision-making around safeguarding clear and defensible in James's case? Is this typical practice in Trafford?
14. Was the rationale for decision-making around mental capacity clear in James's case?
15. How does information-sharing that is relevant to someone's mental capacity, and mental capacity assessment itself, need to be improved within and across services in Trafford?

Based on these initial KLOEs and discussion with the agency leads in the first stage of the review, 3 key themes of interest were generated by the independent reviewer with sub-themes added to address the most important emerging issues from the review process. These are:

i. Multi-agency communication and co-ordination of care and support for a vulnerable adult with complex care needs

- Protocols for information sharing around vulnerable adults
- Local procedures for identifying, supporting and protecting vulnerable adults at high risk of harm

ii. Managing vulnerability and risk

- Type 3c diabetes care
- Medical self-neglect
- Suicide risk
- Alcohol dependency
- Homelessness
- Domestic abuse

iii. Prompt safeguarding and mental capacity interventions

- Effective use of the safeguarding system
- Information-sharing and assessment of mental capacity

1.5 Good practice learning points

The review has highlighted a series of good practice points from different agencies who supported James at challenging points in the final year of his life. The most notable of these are highlighted here:

- The homelessness team worked flexibly with James by leaving emergency accommodation open to him for several days, even though his use of the bedspace was not always consistent. Because of his evident vulnerability, the Council never took the position that their homelessness duty to James had been 'discharged' – in practice, this meant that James could return for support multiple times in relation to being homeless. On at least one occasion, James was also returned to homelessness accommodation in the Trafford area to be closer to his family, because he had previously had to be placed out of borough due to no homeless accommodation being available in Trafford.
- Several agencies acknowledged the good collaborative working between the 2 community substance dependence workers who supported James and the Trafford homelessness team
- The Police assessment of their contact with and responses to James was that it was largely in line with expected practice. James was flagged as a vulnerable adult, both through routine Police processes which led to 'care plans' being submitted and shared with partners, and via the Multi-Agency Risk Assessment Conference (MARAC) process. The review has identified that the Police appeared to have the most complete view of James's social and medical issues, some of it directly disclosed by James's family, and this was shared within MARAC meetings
- Although the review heard that the domestic abuse risks relating to James and his family did not seem to be high-risk in terms of the potential for serious harm, escalating the alleged bi-lateral domestic abuse into the MARAC arena was seen as helpful because it recognised the overall vulnerability of the family
- Trafford Domestic Abuse Services noted that the Independent Domestic Violence Advocates (IDVAs) allocated to work with James persevered to engage him, including having some candid conversations with James that openly recognised his vulnerabilities
- Several agencies recognised the strong advocacy in relation to James's vulnerability by the community substance dependency workers during the multi-agency meeting that took place in October 2024. This included pushing for a mental capacity assessment
- It is also important to identify that several practitioners and teams were persistent in raising safeguarding concerns about James, formally and informally, between March and June 2024 – including the homelessness team, the community substance dependency practitioners, the hospital ED and the GP

1.6 Summarising commentary

This review has considered the very complex circumstances and multiple health, housing and care needs of an extremely vulnerable man who very sadly appeared to be in a state of crisis during the final year of his life.

There are undoubtedly issues which made it more challenging for professionals to effectively support James, including:

- His recent arrival in Trafford
- His relatively limited history with Trafford services and hospitals prior to 2024
- His homelessness
- His complex range of high and specialist needs challenged individual professionals' range of knowledge and skills, and their ability to identify with clarity the chief risks to James's safety and wellbeing
- The way public services are organised and administered does not naturally lend itself to working with an adult who is insecurely housed, who may move frequently and cross administrative and geographical borders
- Unfortunately, James was already unwell when he moved into Trafford and once there he appeared to experience very few stable periods or periods of abstinence, where it may have been possible for professionals to work more consistently and productively with him

Despite these factors, the review has seen that there were multiple missed opportunities, across agencies and professions, to support James effectively, including using the legislative frameworks and safety nets designed to protect and support vulnerable adults, such as the Care Act, the adult safeguarding system and the Mental Capacity Act. The fact that these missed opportunities, failings in information-sharing and a lack of urgency to intervene were evident across *numerous* professions and settings, may suggest a lack of confidence and leadership in Trafford to foster inter-professional communication and collaboration in the response to very vulnerable adults. At the most basic level of practice, this involves calling an MDT.

The late Care Act assessment and safeguarding response, along with ongoing confusion about how to and who was responsible for managing the risks around James's insulin use, impeded the earlier instigation of formal multi-professional discussions to co-ordinate the complex wrap-around care and support that James required. In addition, this meant that a small number of front-line practitioners who were regularly in contact with James, were holding the significant risks he was experiencing, without the expert knowledge and support of other colleagues. Fortunately, once the safeguarding process was initiated, it is evident that professionals began to collaborate and act together. A full mental capacity assessment also commenced at this point.

However, the review has highlighted multiple concerns around the safeguarding process, in particular the accurate articulation and prioritisation of safeguarding issues when an adult has numerous risks, and how well these risks are interpreted and screened by Adult Social Care colleagues. The review recommends some fine-tuning of the safeguarding system and support for practitioners, so that adults with a very complex presentation of needs and risks are thoroughly assessed. Explicit definition and recognition of medical self-neglect may be part of this, as panel members felt that this was not a widely understood feature of self-neglect.

The other significant learning from the review relates to the ability and confidence of professionals to challenge the views of other professionals and escalate their legitimate concerns for the safety and wellbeing of an adult. Positively several professionals advocated strongly for James over several months, both informally and formally through the safeguarding system, but unfortunately these concerns were not recognised in a timely way. There are multiple avenues for practitioners and agencies to constructively challenge safeguarding decisions or seek review, but these methods of escalation were not used. Based on the discussions across the review, this may be a matter of awareness of these escalation processes and/or the confidence to use them.

Whilst this review has looked at the specific circumstances of one man in the Trafford district, sadly increasingly more adults with similar life experiences and circumstances to James are becoming the subject of SARs. Trafford SAB and its partners have an opportunity to take the learning from this process to ensure that the existing safety nets and escalation processes that can protect adults who are experiencing multiple, complex vulnerabilities are assertively applied by partners in the future, thereby empowering and enabling front-line practitioners to do the same.

1.7 Recommendations

The recommendations from this Safeguarding Adult Review aim to follow the evidence from the review process. They are organised under the 3 primary themes of interest for this safeguarding adult review and seek to directly address the learning and follow-up actions that the review has identified.

a) Multi-agency communication and co-ordination of care and support for a vulnerable adult with complex care needs

1. The Trafford Safeguarding Adults Board (SAB) should consider and develop with key partner agencies the minimum standards of cross-boundary information-seeking that should be expected from statutory agencies when they first meet a vulnerable adult who has come from outside the Trafford district e.g. the basic enquiries that could be made about:

- their previous care and support needs
- their physical and mental health history
- any specific risks to their wellbeing (e.g. homelessness, substance use, history of self-harm or suicidal ideation, history of domestic abuse etc), including safeguarding concerns

2. The Trafford SAB should seek assurance from its partners that multi-agency meetings (MDTs) for very vulnerable adults with complex health and social needs are promoted and proactively used within front-line teams, as a *routine* approach to sharing information and co-ordinating support to these adults, and, as a method of escalating professional concerns and managing explicit risks

3. The SAB should seek assurance from Adult Social Care that the Care Act Assessment process and training for social care staff adequately equips them to make sound and reliable judgements about the eligibility of adults with non-traditional complex needs to statutory care and support, including specialist high needs supported accommodation where relevant.

4. Whilst the MARAC multi-agency process shared salient information outside of domestic abuse, The Trafford Community Safety Partnership should seek evidence from all partners to the MARAC that they have robust methods for documenting the wider risks to adults that are discussed in the MARAC forum, and this risk profile is used proactively to inform their individual agency follow-up actions

5. The Trafford SAB and its partners should reflect on the learning from the review about the gaps in multi-professional communication and collaboration around a vulnerable adult with complex needs. It should seek to understand if there are any pragmatic, systemic or attitudinal barriers that prevent this professional join-up

b) Managing vulnerability and risk

6. The SAB should host a multi-agency discussion with senior representation from primary care, community and hospital alcohol teams and specialist diabetic teams serving the Trafford district. This should be with a view to:

    - Fostering lines of professional communication between these teams/services to facilitate the ‘shared care’ of adults who are alcohol dependent and living with insulin-dependent diabetes

- Ensuring that there is a common understanding of clinical responsibility and oversight of complex adults with insulin-dependent diabetes between Primary Care and hospital specialisms
- Considering if referral pathways should be established between community/hospital alcohol teams and specialist diabetic teams, for adults with Type 3c diabetes who present as high-risk in terms of their insulin use
- Reflecting on the use of Mental Capacity Assessment (including a consideration of executive functioning) and local risk management protocols for insulin administration for alcohol dependent adults who have fluctuating capacity and/or alcohol-related memory problems or dementia-like symptoms (e.g. Korsakoff's syndrome)

7. The SAB is encouraged to consider with partners how the learning from this review around the specific issue of *medical self-neglect* should be disseminated, which may include choosing to define medical self-neglect with pertinent examples and introduce it as a working safeguarding term across Trafford

8. The SAB and Trafford Suicide Prevention Board are asked to collaborate on how to take forward the learning from this review, particularly relating to:

    - the weakness in information-sharing between professionals about vulnerable adults with a history of suicide or active suicidal ideation
    - practitioners being alert to the risks of escalation in suicide for adults who are living with multiple social and health vulnerabilities
    - the extent to which the findings from this review indicate the need for additional training and resources around suicide awareness and prevention across Trafford

9. The SAB and partners should clarify and reinforce for all agencies working across Trafford the current escalation routes for safeguarding issues, for example, where professionals' concerns are serious and ongoing, including:

    - For individual practitioners
    - Within a single agency/setting
    - Agency to agency
    - To Adult Safeguarding in Adult Social Care
    - To the SAB

10. The Trafford SAB should seek relevant evidence and examples from organisations and agencies who frequently work with adults who have multiple, complex vulnerabilities and who regularly present in crisis, which

demonstrate that their safeguarding supervision and advisory arrangements are fit for purpose and sufficient to meet the level of risk practitioners are holding

c) Prompt safeguarding and mental capacity interventions

11. Adult Social Care should work with SAB partners to refine and improve aspects of the formal safeguarding process, including:

- Considering amendments to the safeguarding referral form to support better articulation of safeguarding risks by the referring practitioner
- Where there are multiple safeguarding issues, consider how to support the referrer to clearly define and prioritise the risks of harm/abuse/neglect accurately
- The screening and interpretation of safeguarding referrals by Adult Social Care, including looking across all previous safeguarding referrals to assess the overall level of risk and/or escalation over a period of time
- Strengthening the feedback loop to referring practitioners/agencies so that they understand the outcome of their referral and the rationale for the safeguarding decision – this may be informed by an audit
- The option for agencies to challenge/escalate a safeguarding decision if they have ongoing concerns about an adult

12. The SAB should seek assurance from Adult Social Care that current safeguarding screening is fit for purpose, specifically the effectiveness of screening to accurately identify the safeguarding risks experienced by adults with multiple and complex social, housing and health issues, who may not have traditional social care needs

13. Manchester University NHS Foundation Trust (Wythenshawe Hospital) Emergency Department should introduce a ‘regular attender’ policy which establishes systems that allow ED staff to easily flag patients that have high attendance at ED. The policy should also highlight how this information will be actively monitored and reviewed and how it will inform safeguarding decision-making

14. The SAB and relevant partners are advised to collectively review their arrangements around Mental Capacity Assessment to satisfy themselves that current training, systems and MCA processes are adequately understood and implemented by practitioners and managers. This should consider:

- Does local MCA training sufficiently explore the concepts of fluctuating capacity and executive functioning
- The robustness of information-seeking, sharing and recording that is directly relevant to mental capacity e.g. family or self-reports of memory loss, signs of dementia-like symptoms, the findings of previous brain-scans, concerns around an inability to retain or use information appropriately
- What is the process for professionals seeking support with mental capacity concerns in complex and high-risk scenarios - where it may not be possible for them to reach a conclusion about capacity in isolation for example
- More use of jointly conducted MCA assessments
- Clarifying the route to accessing a formal MCA assessment where there are serious and ongoing concerns about an adult's mental capacity to understand, retain and follow advice to keep themselves safe

2. Analysis by the key issues explored in the review

2.1 Multi-agency communication and co-ordination of care and support for a vulnerable adult with complex care needs

a. Protocols for information sharing around vulnerable adults

It has already been highlighted earlier in this report, that it does not seem to be standard practice for information about vulnerable adults to be shared across geographic/administrative boundaries i.e. between different Police forces, different Council areas etc in the same way that information might be shared automatically around vulnerable children. This means that unless there is explicit guidance and procedures at an organisational level (none was suggested to exist by the agencies who participated in the review), individual practitioners and services will decide at their own discretion whether they need to understand an adults' history with other services in a different region to assess and support them effectively.

For an adult with relatively routine presenting needs, it's likely that the individual can supply all relevant information themselves. However, for an adult like James who was extremely vulnerable due to his multiple complex needs and life experiences, and who may not have been able to reliably report his own health and care history due to his alcohol dependency, some services recognised that it would have been good practice to make some basic enquiries with relevant services in the Council area that James had previously lived in Cheshire East.

Given that cross-boundary systems (i.e. between Cheshire East and Trafford) do not appear to exist for sharing routine information around vulnerable adults, the learning

from James's circumstances may provide the impetus for considering this at a Trafford SAB level. Information sharing and seeking is especially relevant in the context of vulnerable adults who are homeless, as homelessness by its nature leads adults to be more likely to move between areas to find accommodation and a place of safety.

However, the review has also found that where existing fora or processes for sharing information about vulnerable adults ***within*** the same area exist, they were not always an effective means of agencies recognising, absorbing and acting on relevant information.

A specific example of this is the information sharing in the MARAC forum, where James's circumstances were first heard in March 2024. It is obvious from the chronology, that Police gathered a relatively complete picture of James's diverse needs and issues, including his alcohol dependency, his diabetic status, chronic pain from pancreatitis and a spinal fracture, memory issues and probable early onset Alzheimer's-like disease from January 2024. The Police were also aware of his frequent suicidality due to several episodes where they were called to assist James. This account appears to have been gathered, at least in part, by speaking to James's family members.

When information sharing was discussed in the agency conversations and at the Practitioner event, and to what extent the services working with James understood the different dimensions of his vulnerabilities e.g. his memory problems/dementia-like symptoms, his suicidality, the use of insulin for his diabetes, very few practitioners felt that they were aware of the complete picture. However, Police colleagues were very confident that relevant information to be able to form a holistic view on the risks to James were shared within the MARAC arena, which met on 4 occasions. The evidence seen in the review seems to support this.

Confusingly, some agencies did have accurate records about James's memory problems, with the community mental health team documenting in their records in July 2024 that James had a diagnosis of Alzheimer's disease. Similarly, ASC case records refer to Jamess suicidality, which was shared as part of a comprehensive safeguarding referral in April 2024.

These examples highlight that between agencies, there was a relatively complete picture of James, however, no single health, care or support agency (except for the Police from a criminal justice point of view) seemed to have a holistic view of these complexities at their disposal or gathered this information in their contacts with James.

The findings from the review point towards the chief failing around information sharing and risk analysis was the late use of multi-disciplinary professionals' meetings including the initiation of the s42 enquiry. Considering Jamess circumstances and needs 'in the round' would have facilitated a conversion of the different aspects of James's care and support needs into workable 'intelligence' that would have enabled practitioners to see the complete picture and co-ordinate their response – including assertively seeking wider specialist and clinical input. One

agency observed that in part this was because no agency took early responsibility for calling a meeting to bring the practitioners and information together.

The evidence from the review processes suggests that this was largely true for the period from January – June, and whilst there are several references in case notes from late Spring to the need for an MDT, this does not seem to happen until the s42 safeguarding enquiry was launched in July, after which multi-agency communication and information-sharing improved significantly.

The other aspect of information-seeking and sharing that is relevant in James's scenario is consultation with James's family and how that feedback was used to inform support for him. From January 2024, the Police had gathered a largely complete picture about James with his family's help, which was followed by numerous other professionals being in contact with the family, including at the point of the s42 enquiry. It appeared evident across the chronology that James's family were a protective factor for him, providing him with accommodation, monitoring his blood sugars, supporting the safe use of insulin, advocating for him and actively seeking out the help of the GP and mental health services.

However, it is also recognised that James's family dynamics and relationships were complex and repeated allegations of bi-lateral domestic abuse between family members may have masked the level of help and support James was receiving from his sister and mother. Some practitioners also reported a tension they experienced in balancing family input, with hearing James's voice and wishes first-hand. This left some practitioners doubtful about the helpfulness of ongoing family involvement.

This was undoubtedly a complex scenario for practitioners to navigate, however, as with other learning about James's care, the emerging solution is that earlier and more co-ordinated communication between professionals may have led to better engagement and co-operation with the family and a more complete understanding of James needs and risks. The family themselves reported feeling more confident about professional input into James's care in the few months before his death, through the relationship with the social worker leading the s42 enquiry.

b. Local procedures for identifying, supporting and protecting vulnerable adults at high risk of harm

One of the questions posed by the review is what processes are available to practitioners to enable them to identify, support and protect adults like James with multiple complex needs, whose vulnerabilities place them at increased risk of harm, including self-neglect and self-harm.

The main opportunities identified in James's scenario are:

- MARAC
- The formal Adult Social Care assessment process or Care Act Assessment (CAA)
- Using the formal safeguarding system

- The Trafford MARM framework (Multi-agency risk management)

It has already been mentioned that James and his family were under discussion within the Trafford MARAC domestic abuse multi-agency forum, however, as several contributors pointed out, these discussions are often brief due to the number of cases that are considered at each meeting. In addition, the focus of the MARAC is to manage the risks associated with domestic abuse, however, there is evidence that agencies in attendance were allocated wider actions, including ASC, the hospital safeguarding team, the homelessness team etc to address James's needs beyond his domestic abuse risks. ASC has reviewed their role in relation to MARAC and on reflection have accepted that the information being shared within the MARAC meetings clearly indicated the need for a multi-professional meeting outside of MARAC, which was not initiated.

One of the actions ASC was tasked with appears to have been to explore James's care and support needs through a formal social care assessment. There is agreement across agencies that James was first referred into ASC for a Care Act assessment in January 2024 by the homelessness team. ASC case records state that there were a further 9 requests for assessment recorded on their care management system. A Care Act assessment did take place at the end of April 2024 but it was reported to other professionals, including the MARAC meeting, that James did not have Care Act eligible needs and that the focus for supporting James should be the management of his diabetes and alcohol use.

Several of the agency conversations referenced an apparently delayed response to the requests for social care assessment by ASC, whilst others questioned the adequacy and thoroughness of the assessment for it to have concluded that a man as vulnerable as James did not have care and support needs, given his alcohol dependency, diabetes and the multiple professional concerns expressed around self-neglect. At the point of the Care Act assessment, it should be noted that 5 safeguarding concerns had already been made in relation to James, three of these were repeated concerns made by the hospital ED.

This poses questions about the depth and quality of the adult social care assessment that took place on 24 April 2024, which James attended with his sister, and the related consideration of the safeguarding concerns made around that period. In their review of the case, ASC has acknowledged that there was enough information at this point to make a professional judgement that James had care and support needs, there was evidence of self-neglect, and due to the ongoing and complex nature of the concerns he was unable to protect himself. The explanation for the oversight of the safeguarding referrals is that they were treated as being linked to the ongoing work to complete a Care Act assessment and were not considered new issues. They were however a clear indicator of escalating professional concern for James from a range of different services.

There is considerable learning for ASC around the reliability and depth of Care Act assessment for adults with complex vulnerabilities, how safeguarding concerns are interpreted and screened at point of receipt, and how all available current and historic information is considered to inform an accurate assessment of safeguarding risk. There may also be a specific need to refresh social care practitioners' understanding of self-neglect - specifically the implications of medical self-neglect and medical self-harm, with example scenarios that help to highlight the risk of harm.

How the formal safeguarding system was used to support and protect James will be addressed in section 2.3a below.

The final option to support James was to consider using the Trafford multi-agency risk management framework (MARM). Most agencies said that they were not aware that MARM had been considered and some felt that this was unlikely given that James was open to the MARAC process. It was noted that MARM has been designed to be used preferentially, where an adult's risk of harm does not fit into any other public protection framework. There was broad agreement across the agency conversations that the safeguarding framework afforded by the Care Act was the most appropriate way to address James's risk of harm, given his clear care and support needs and self-neglect.

2.2 Managing vulnerability and risk

Whilst James's vulnerability was a complex, intersecting mix of the issues discussed in this section and needed to be understood holistically by professionals, the main risk areas are addressed individually so that the learning and necessary actions are more evident.

a. Type 3C diabetes care

One of the specific and very complex aspects of James's care and support needs was his self-administration of insulin to manage his type 3c diabetes, against a background of fluctuating capacity due to his alcohol dependency, his tendency towards insulin overdose, and poor mental health with suicidality and a history of non-fatal suicide.

Although unusual, this scenario will not be unique to James because type 3c diabetes is a consequence of alcohol dependency and so the review has tried to understand what routine clinical protocols are available to manage and support an adult who is living with insulin-dependent diabetes, but who may not always be able to administer their insulin reliably and safely due to their use of alcohol. There are obviously significant inherent safeguarding risks in this scenario, by administering too little and/or too much insulin, both of which could lead to death, so the review sought to understand if there are any recognised measures or approaches that mitigate the risks for an adult living with alcohol dependency alongside type 3c insulin-dependent diabetes. The review was told that a 'locked box' approach, with

support from District Nurses to administer insulin, is the typical method for managing these types of risk. However, this remains an extremely difficult situation to manage, as District Nurses would not administer insulin to an intoxicated adult, if there was a risk of the person not eating within a short timeframe etc

With input from a specialist diabetic team at the Manchester University NHS Foundation Trust hospital James attended regularly, it has been possible to understand what diabetic care and advice James received:

- Two GP referrals were made into the two specialist diabetic teams that serve the Trafford district. The first of these was in April 2024 and the referral was accepted but it is understood that the waiting list to be seen by a Consultant was significant. The second was in October 2024 which was also accepted and an appointment was planned for December 2024. Another GP referral also appears to have been made in July 2024, but this was interpreted as a request for diabetic retinopathy (eye) screening
- Whilst an inpatient at two MFT hospitals, James was also seen on the Ward by specialist diabetic nurses, but this largely involved advice to James around insulin administration and nutrition i.e. the day-to-day management of diabetes. It appears that James's tendency towards both accidental and intentional overdoses of insulin and his frequent suicidal ideation was not explicitly shared
- On his hospital admission in October 2024, it does seem that the concerns about James's capacity to use his insulin safely, discussed at the safeguarding MDT whilst James was admitted, were communicated to this hospital via a referral from the GP. This appears to have resulted in a request from the specialist diabetic team at this hospital for District Nursing to support James with his insulin administration post-discharge

Although case notes highlight that several agencies had concerns about Jamess use of insulin, understood the risks to his life and raised this with social workers, unfortunately, most of the responses highlight a fundamental lack of understanding about the urgent risk of medical self-neglect characterised by James's circumstances. One case note as early as April 2024 records an account where it was '*recommended for independent formal support to be arranged, for example district nurses to be considered'* to support James's insulin use, however, it wasn't clear whose responsibility it was to action this advice or who had suggested it.

Some measures to protect James by supporting his insulin administration and assessing his capacity to do so safely did seem to be actioned shortly before his death and this happened in the context of the s42 safeguarding process, however, there was a lack of relevant information sharing across hospital specialisms on previous admissions. For example, had the specialist diabetic nurses that visited James on Ward been made aware of James's history of intentional and accidental insulin overdose, the concerns about his memory loss and capacity to self-administer insulin, it is possible that an earlier referral for District Nursing support would have

been made, which may in turn have led to more robust measures to address James's risk to himself

At no point did any professional working with James outside of the hospital setting appear to directly seek advice or guidance from community or hospital-based specialist diabetic teams about their safety concerns, which would perhaps have been the most obvious course of action when dealing with high levels of uncertainty and risk. However, the review heard that there was no known route to do this as there is no referral/care pathway or channels of communication between community specialist substance dependency teams and the specialist diabetic team, which need to be established in the future so that adults like James can be better supported. Practitioners acknowledged that this communication and co-working was absent from Jamess care and would have supported them as practitioners.

Based on the account that has been gathered, the conclusion of the review is that:

- there was confusion about who had the clinical leadership and oversight for James's insulin management, especially whilst James was on the waiting list for outpatient input from a diabetes Consultant, even though James had numerous hospital admissions and was likely to have been under the care of the same team
- the response to the risks presented by his insulin use lacked urgency and focus
- relevant information that could have informed clinical and risk decision-making and prompted earlier intervention was not adequately shared within and between professionals working in the community and hospital

b. Medical self-neglect

Perhaps due to James's complex range of issues, medical self-neglect was not adequately highlighted or understood as the primary, active factor in the risks to James. For example, whilst some safeguarding concerns did refer to self-neglect, the specific circumstances of Jamess medical self-neglect linked to his insulin use, alongside his background of frequent suicidal ideation and history of insulin overdose, did not seem to be specifically highlighted in safeguarding concerns. Nor were they recognised in the Care Act assessment or from the body of formal and informal safeguarding commentary by professionals.

Although case notes show that some practitioners did recognise this risk e.g. the hospital Alcohol Liaison Team, the community alcohol outreach worker and raised it, unfortunately, it did not seem to gain traction with colleagues until it was discussed within the safeguarding MDT in July 2024. This may suggest a training and development issue across Trafford partner agencies around medical self-neglect and/or the complexities and implications of being insulin dependent.

c. Suicide risk

Numerous agencies said that Jamess suicide risk and history of non-fatal suicide was not known to them. In fact, of all the issues that were discussed as part of the review, the feedback from agencies and practitioners was that his risk of self-harm was the least well-understood aspect of James's risks. This is highly relevant because James readily had the means to intentionally harm himself by taking an overdose of his insulin.

Although Jamess suicidality was also said to have been shared within the MARAC arena, the Police, the hospital EDs James attended and Adult Social Care appear to have been the agencies that had a clear record of James's history of non-fatal suicide and active suicidal ideation, however, it is fair to say that the most frequent recording was in the hospital health records and mental health liaison team records associated with James's frequent visits to ED.

This suggests a weakness around relevant information-sharing across agencies and how risks are highlighted and prioritised. Trafford partners also need to consider if suicidal ideation and past non-fatal suicide are adequately heard and recorded by all agencies in multi-agency forums and if there is a training need around suicide prevention and risk across the Trafford adult safeguarding partnership. One agency noted that the challenges of mental health practitioners being able to attend MDTs/MARAC (due to capacity in mental health services) is a well-known issue and alternative ways of engaging mental health professionals may need to be considered.

d. Alcohol dependency

James's alcohol dependency was the most obvious of his risks and he received early support from both community and hospital alcohol teams. However, like many alcohol-dependent adults, James struggled to engage fully with the processes that are necessary to prepare for detox and rehabilitation programmes. On the occasions that he was supported to safely medically detox whilst admitted to hospital, he quickly returned to using alcohol.

The substance dependency practitioner who contributed to the review clearly felt a degree of isolation in trying to support James and although there were two community substance dependency workers who regularly had contact with James and collaborated around his care, those two professionals were primarily holding all the risk.

Consideration should be given to whether Trafford professionals working with very complex adults in any service arena have clear routes to escalate their safeguarding concerns about an adult, within their own organisation and beyond. It may also be helpful to review the availability of safeguarding supervision in teams who regularly encounter or work with adults with complex needs, including alcohol dependency.

e. Homelessness

There is learning from James's experiences around how to support a homeless adult with high-risk care and support needs. The review has seen that the Trafford homelessness team repeatedly flagged that James could not be supported effectively in emergency temporary homelessness accommodation and the homelessness professional felt a clear sense of responsibility that no other accommodation could be offered to James, despite knowing that what was available from a statutory homelessness perspective could not meet James's complex care and support needs.

Alternative specialist supported accommodation that James may have benefitted from would only have been available through a Care Act assessment (CAA) which identified that James had associated care and support needs. The absence of an accurate CAA therefore delayed the consideration of more suitable specialist accommodation for James, although this process did commence as part of the s42 enquiry from July 2024.

f. Domestic abuse

Although the response to the bi-lateral allegations of domestic abuse around James was appropriate, there is a sense across the review that the awareness of potential domestic abuse against James may have detracted from professionals being able to accurately recognise the more immediate risks to his wellbeing.

Several safeguarding concerns focused exclusively on James potentially being a victim of domestic abuse but overlooked the many other factors that characterised his vulnerability and presented a risk of harm to him.

2.3 Prompt safeguarding and mental capacity interventions

a. Effective use of the safeguarding system

Although the safeguarding system was deployed, the repeated sense from the chronology and conversations across the review is that a fulsome safeguarding response was slow to be initiated. Based on the information in the chronology, the first specific note of a formal safeguarding concern being raised by any agency in relation to James was on 14 March 2024. This was initially raised by the hospital ED and was followed by a further 8 safeguarding concerns raised by different agencies, the final one being on 29 June 2024, when s42 safeguarding enquiries were then initiated on 2 July.

There are two notable delays. The first relates to James's very high attendance at the same hospital ED and the lack of a robust safeguarding response to this, given James's vulnerability. From 1 January to the end of February 2024 James attended

hospital ED on at least 16 separate occasions, sometimes with an ambulance crew, sometimes self-presenting. A safeguarding concern raised by the hospital alcohol team stated that James attended ED a further 11 times in March 2024. The hospital has recognised that whilst James was 'flagged' on their systems as regularly absconding before treatment and as being a victim of alleged domestic abuse, there was no organised way to track the extent of Jamess attendance at the time or alert other colleagues to the frequency of it. It was accepted at the practitioner event that this is important learning for ED and the introduction of a 'regular attenders' policy will make it easier in future to identify vulnerable adults who have high attendance and consider proportionate safeguarding action.

The second delay is in the safeguarding response by ASC, given the number and nature of the formal safeguarding concerns that were raised about James, but also the number of informal contacts made by other professionals directly expressing concerns via e-mail to social workers/social work assessors about James, including from the homelessness team, the community alcohol workers and the GP. In addition to this, ASC were represented in the MARAC forum where James was discussed. ASC has recognised that there were multiple weaknesses, both at the point of Care Act assessment and in the safeguarding response, including what appears to have been a failure to properly take into account the accumulation of safeguarding and professionals concerns about James and his previous brief but similar safeguarding history in Trafford dating back to Autumn/Winter 2022.

The ASC chronology states that James was open to the central area social work team from mid-May 2024 and at the practitioners' session it was stated that while someone is open to ASC, a safeguarding enquiry can be opened at any time by the lead social worker. The escalation of professional concerns for James during June therefore appears to have triggered the s42 safeguarding enquiry – these may have included a care plan multi-agency meeting called by the Police and apparent pressure from James's GP to move to a professionals meeting.

Despite the slow safeguarding response, when the s42 enquiry was initiated, the review has seen clear evidence of improved communication between professionals and co-ordination of the response to James, with the social worker taking the lead in this. Case notes suggested some ongoing confusion between professionals about James's type 3c diabetes care and the response to James's need for specialist accommodation proved difficult to action quickly. Comments in the Practitioners sessions reinforced this perception, as practitioners identified what they perceived as the absence of specialist diabetic input in James's care, partly due to poor information sharing, and a gap in higher-needs accommodation in Trafford as ongoing barriers in their collaborative efforts to support him.

Another area of learning relates to the clarity of safeguarding referrals and the way they are screened in Trafford. It seems that some of the March 2024 safeguarding referrals made about James were screened out as a referral for social care assessment or apparently resolved through a short conversation with James.

Although some of the referrals did clearly state concerns around self-neglect, the focus for others was on James's ability to access his medications and his risk of domestic abuse for example.

For an adult like James who had very complex needs, a safeguarding concern may well be multi-faceted, but it would seem that some of the safeguarding concerns that were made and the way they were screened failed to get to the heart of one of the main risks to James's health, wellbeing and safety, which was his fluctuating capacity to safely self-administer insulin, his history of insulin overdose – which indicated an ongoing risk of medical self-neglect - and enduring suicidality.

b. Information-sharing and assessment of mental capacity

Although James's 'in the moment' mental capacity was assessed on many occasions, typically in a hospital setting, none of these assessments seemed to uncover or explicitly consider three factors – that James frequently reported having memory problems, that his capacity could fluctuate significantly due to his use of alcohol, and that there were both first-hand accounts and records which suggested that he was suffering with a form of early-onset dementia. In addition, none of these issues were linked to his medical self-neglect.

On one occasion in June 2024, James visited the hospital he attended regularly. His presentation on this visit, which included him experiencing auditory and visual hallucinations and an inability to understand or retain information, led to a Deprivation of Liberty Safeguard (DOLS) being requested because there were concerns that these symptoms were not due solely to intoxication. The clinical investigations included a brain scan which identified that James had generalised atrophy to his brain, which was not consistent with his age. Unfortunately, James chose to discharge himself from hospital before this could be fully investigated and the records simply noted that he was considered to have capacity to make this decision at the time. The status of the DOLS request was not documented. In a later visit to the same ED, James underwent another mental capacity assessment, but the information provided by the brain scan did not seem to form any part of the consideration of his mental capacity in this or later assessments.

This is one example that highlights the weaknesses of mental capacity assessment in a hospital setting, however, the agency conversations pointed towards wider issues with the use of mental capacity assessment (MCA) across Trafford partners. There was a view that 'executive functioning' (the ability of an adult to follow-through on things that they agree to do or say that they can do) is not always considered in MCAs, nor may it be possible to draw any conclusions around an adult's executive functioning based on a single contact or episode. Agencies also said that in very complex or high-risk circumstances, it may not be reasonable for a clinician or professional to make a decision about an adult's mental capacity in isolation, but it is

not necessarily clear where to go for help or advice if they find themselves in this situation.

There was some frustration that when formal MCAs are requested, there can be push back from statutory services if the adult is alcohol dependent, or, initial assessment results in a judgement that the adult has capacity despite practitioners having legitimate and reasoned concerns. Other observations from agencies were that MCA is often not holistic.

Although MCA is a notoriously complex area of practice, made yet more complex when adults like James experience multifaceted problems, the findings from the review point towards a need for Trafford partners and the SAB to carefully review whether professionals across key services currently have the confidence, skills and support to make accurate decisions about an adult's capacity, which includes understanding when a capacity assessment is indicated and the information that should be taken into account when making decisions around capacity. One observation was that future MCA training should be more practical and use real-world examples to help colleagues understand and apply MCA in practice, rather than as a legal concept. Training should also incorporate a greater focus on executive functioning and how professionals can build this into their judgements about an adult's mental capacity.