Safeguarding Adult Review
Michael

Approved by the Bury Integrated Safeguarding Partnership (BISP) SAB (Safeguarding Adults Board - 5th October 2022)

Independent Reviewer
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This report is strictly confidential and must not be disclosed to third parties without discussion and agreement with the BISP prior to publication.

Contents

1. **Brief Summary of Circumstances resulting in the Review** **3**

2. **Safeguarding Adult Review Process** **3**

2.1. Methodology *3*

2.2. Time Period reviewed *4*

2.3. Parallel Reviews and Processes *4*

2.4. Family Engagement *4*

3. **Who was Michael?** **4**

4. **Understanding Dual Diagnosis** **7**

5. **Thematic Analysis** **7**

5.1. Theme 1: Referrals and Assessments *7*

5.2. Theme 2: Integrated Neighbourhood Teams *15*

5.3. Theme 3: Executive Functioning *17*

5.4. Theme 4: Hard to Reach Service User *18*

5.5. Theme 5: Family and Community *21*

5.6. Theme 6: The Effects of the Covid Pandemic *24*

6. **Good Practice** **26**

7. **Improving Systems and Practice** **27**

7.1. Developments since the Scoping Period of this Review *27*

7.2. Conclusion *28*

7.3. Questions for the BISP *29*

8. **Appendix 1** **30**

1. Brief Summary of Circumstances resulting in the Review

1.1. This Safeguarding Adult Review (SAR) was commissioned by the Bury Integrated Safeguarding Partnership (BISP) on the recommendation of the Local Safeguarding Partners in accordance with the Care Act 2014.

1.2. The criteria for this review were met as a male, hereafter known as Michael, was an adult with needs for care and support, and has sadly died.

2. Safeguarding Adult Review Process

2.1. Methodology

2.1.1. Following agreement that the criteria for a Safeguarding Adult Review had been met, an Independent Reviewer[1] was appointed.

2.1.2. The reviewer, whilst ensuring that a streamlined, proportionate approach to reviewing and learning would be taken, sought to engage as many frontline workers and their managers with the review process as possible, to consider why actions and decisions had been taken.

2.1.3. A multi-agency review panel consisting of representation from the agencies involved[2] was established, and the panel met[3] on the 30th of March 2022 to discuss terms of reference[4], chronology timelines, the learning event, and an expected date of completion.

2.1.4. It was agreed at the panel meeting that the review would follow a question-based learning format in place of traditional recommendations. The questions developed during this Safeguarding Adult Review process will drive BISP and its partner agencies to develop an action plan that will respond directly to the identified learning.

2.1.5. The panel further met on the following dates to monitor the Safeguarding Adult Review process and discuss learning:

- 11th of May 2022
- 2nd of August 2022

2.1.6. A practitioner learning event was held on the 16th of June 2022 and was attended by staff from the following agencies:

- Six Town Housing
- Medical Centre
- Mental Health Home Treatment Team
- Bury Council
- Access and Crisis Team Pennine Care
- Achieve
- Greater Manchester Police
- Mental Health Liaison Team
- Integrated Neighbourhood Team
- Adult Social Care
- Children's Services

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[1] Allison Sandiford is an experienced reviewer of children's, adults' and domestic homicide reviews. She has a legal background and has gained safeguarding experience whilst working various roles for Greater Manchester Police.

[2] BISP, NHS Bury Clinical Commissioning Group (In July 2022, The Health and Care Act dissolved the Clinical Commissioning Groups and transferred their powers to Integrated Care Boards), Adult Social Care, Pennine Care NHS Trust, Greater Manchester Police, Greater Manchester Mental Health, Six Town Housing Children's Social Care, Northern Care Alliance

[3] Covid precautions necessitated that panel meetings and the learning event be virtually attended. As such they convened using Microsoft Teams.

[4] Appendix 1

- Northern Care Alliance

2.1.7. Feedback from the participants generated positive discussion around areas of practice that could be developed and improved and also highlighted much good practice. This feedback has formed the basis of the recommendations of this report.

2.2. Time Period reviewed

2.2.1. It was agreed that the timeline for the review should predominantly be from January 2020 until April 2021, when Michael was found deceased. However, there is reference to some safeguarding processes undertaken prior to this timescale as they relate to later agency involvement and decisions.

2.3. Parallel Reviews and Processes

2.3.1. Michael's death was reported to the Coroner. The medical cause of death is reported as an upper gastrointestinal tract haemorrhage, caused by a ruptured oesophageal ulcer. This was contributed to by a background of chronic cocaine misuse and alcohol dependency. The evidence put before the Coroner demonstrated that Michael did not accept support for his alcohol and drug dependency.

2.3.2. Her Majesty's Coroner concluded the cause of death to be 'Misadventure to which a contributory factor was self neglect'.

2.4. Family Engagement

2.4.1. The independent reviewer and the BISP would like to offer their condolences to Michael's family.

2.4.2. BISP notified Michael's mother of this review and invited her to participate. The family's personal knowledge of the deceased is an important aspect of the Safeguarding Adult Review process, and the Independent Reviewer would like to thank Michael's mother for agreeing to meet with her. Her invaluable contribution is woven into the body of the report.

2.4.3. To ensure confidentiality, Michael's mother is to be referred to as Sandra.

3. Who was Michael?

3.1. Documentation provided to this review, and conversations that have been had with professionals who worked to support Michael, evidence that because services struggled to engage Michael, very little was known about his personal life. Michael had disclosed that:

- he had suffered physical abuse at the hands of his father who died when he was nine years old,
- he had started to use drugs when he was 15 years old (he did not disclose which drugs),
- he had worked as a Chef but due to many physical health problems which made it risky for him to be in the kitchen, he had to leave this job,
- he had two children, and
- following a suicide attempt, he had a brain injury which had a long-term effect on his short-term memory.

3.2. Sandra informed this review that Michael had been a happy youngster who was full of energy. As a young child he had lived with her, his father, and his younger brother. Sandra spoke of her surprise when she learnt of Michael stating that he was abused as a child by his father. Sandra said Michael's father developed an addiction to alcohol, thought to have been exacerbated by pressure at work, when Michael was young, but that he fought this addiction and kept it under control for several years. Unfortunately, he relapsed when Michael was around 12 years old and as a result, Sandra separated from him. Michael did not maintain contact with his father who sadly passed away when Michael was 15 years old.

3.3. Sandra described Michael as an outgoing boy who was very trusting and consequently had always been easily led by peers. She recalled that Michael's substance misuse began when he started catering college and doubts that it could have started earlier as she feels sure that she would have noticed something.

3.4. Michael lived with Sandra until he was in his twenties when he left home to move in with a girlfriend. The relationship lasted about five years.

3.5. Michael subsequently started a new relationship with a lady with whom he had two children. Their relationship was good at first, but Michael's substance misuse worsened after the birth of their first child and eventually they separated. Michael returned to live with Sandra, who had by this time remarried.

3.6. Sandra explained to the review that when under the influence of drink and/or drugs, Michael could become aggressive and insulting, and this understandably affected many of his relationships. Despite this, Michael remained respectful to Sandra, and she was usually able to calm him.

3.7. Initially when Michael returned to Sandra's home after his relationship had broken down, he engaged with 1-1 in Bury and, for a while managed to control his addictions, but unfortunately the improvement was not sustained. Michael stayed at Sandra's address for a few years and in this time, there were two suicide attempts and ongoing substance misuse. It was around this period of his life that Sandra recalled Michael had last worked. Sandra remembered that Michael was a Chef in a care home for the elderly and that Michael was very popular with the residents as he loved to chat with them. Unfortunately, his employer had to terminate his employment after he attended in an inebriated state. This effectively ended his catering career as Michael was unable to provide any favourable references to future employers.

3.8. In desperation Sandra paid a substantial amount of money for Michael to attend a rehabilitation centre and for a while Michael was substance free.

3.9. Following from this Michael decided that it was now time for him to get a flat and live independently. Sandra recalled that she and her husband had many reservations as Michael hadn't ever lived alone and in Sandra's opinion didn't like to be on his own. However, they helped Michael to gain a tenancy on a flat in the Bury area and supported him emotionally and financially. Sadly, Sandra said her predictions were proven true and Michael very quickly declined and started to hang around with a crowd of people who she believes encouraged drink and drug use.

3.10. Michael maintained a mostly amicable relationship with his ex-partner, although domestic incidents did occur when Michael was under the influence. The ex-partner encouraged contact between Michael and the children. Sandra spoke of how Michael would be in a good mood when he had spent the day with his family at his ex-partners home. Sandra recalled that the ex-partner was supportive of Michael and would offer to help him clean his flat, but Michael rarely allowed either the ex-partner or Sandra into his flat to clean up.

3.11. In time, Michael was evicted from his flat and Sandra helped him to move into a privately rented flat in Radcliffe. It was whilst Michael lived at this flat that Michael jumped headfirst from his 1st floor window and sustained injuries. Sandra was told by the police officers who attended the incident that Michael had been found crawling around with injuries. Sandra said she had been amazed that Michael had been conscious and that despite suffering traumatic brain injury with complex skull fractures and small traumatic sub-arachnoid haemorrhage, was out of hospital after a week.

3.12. As a result of the injuries, Michael suffered short term memory loss. Consequently, Sandra transported Michael to frequent and multiple appointments to ensure that he attended. Sandra recalled head trauma appointments, appointments at Salford Royal hospital with a clinical psychologist and mental health appointments at Fairfield. In addition, she said that she was also taking Michael to North Manchester Hospital for appointments as he suffered hepatitis C. Sandra said that at the time Michael told her that he wasn't drinking but she suspected that he was, and also that he was probably still using drugs. Around this time Sandra supported Michael to get a ground floor flat as she thought that this would be safer for him.

3.13. Sandra told this review that Michael would contact her on a very regular basis and that it was not unusual for him to phone her four times a day. She considered Michael to be relatively open about his problems and she supported him as much as she could. Michael had told Sandra that he had good friends who regularly came to his flat, but Michael also told her of money going missing from his bank account and admitted that he would give his 'friends' his bank card and Personal Identification Number. Sandra told him not to do this, but he continued to do so. Sandra recalled many times when amounts had been taken from his account or purchases had been made by other people.

3.14. As a result of Michael's poor money management Sandra supported him financially constantly. She topped up his rent and would often pay for gas and electric. Sandra informed this review that she had been aware of how she could apply for Power of Attorney to help Michael manage his financial affairs but when she had discussed this with him, Michael had declined. Sandra said that she had often thought about overriding his wishes and applying for Power of Attorney, but she hadn't ever felt that the time was right to do so.

3.15. Sandra presents as a warm loving person who has clearly worried for Michael for a very long time and has constantly supported him in every way she could. It is clear to the reviewer that Sandra provided Michael with a beautiful, clean home and Sandra said that Michael always knew that he had the option to return. Sandra thinks that he didn't come home because her house is a little way from the Bury area where his family and 'friends' were.

3.16. Sandra recognised that Michael did not engage well with professionals. She remembered Michael had once told her that he had stopped answering his phone because in Michael's words; '*they're* [the agencies] *no help anymore'*. Sandra told the review that she now knows that Michael did not want professionals to contact her but wishes that they had. She is unsure what difference contact with her would have made to Michael's recovery, if any, but is certain that she could have helped professionals to understand him and she could have encouraged Michael and taken him to appointments had she known of them. Sandra recalls how his appearance deteriorated around 2020. She described her shock at seeing him very unkempt as he had always had very good personal hygiene. This is the type of information that she considers she could have notified professionals of - had she had a contact.

3.17. Professionals attempting to support Michael, despite knowing little about his personal life and therefore of what might be the underlying drivers to his behaviour, recognised the main concerns as being his substance misuse and his mental health.

3.18. At the learning event professionals considered what support had been offered to Michael and deliberated the barriers to putting the support in place.

The Concern	**The Support Available**	**The Barrier**
Substance misuse	Achieve	• Professionals were unable to maintain engagement with Michael
	Alcohol Liaison Team – treatment plan	• Professionals were unable to maintain engagement with Michael
Mental Health	Home Based Treatment Team Assessment	• Professionals were unable to maintain engagement with Michael
	Community Mental Health Services	• Professionals were unable to maintain engagement with Michael
	Mental Capacity Assessments	• Successful initial assessment on occasions but a lack of professional understanding of executive capacity resulted in this not being considered.
	Care Act Assessment	• Professionals were unable to maintain contact with Michael, therefore professionals did not always

		manage to gain enough information to ensure a thorough assessment of needs.
	Section 136 Mental Health Act	• Professionals were unable to maintain engagement with Michael
	South Ward	• Michael self-discharged

4. Understanding Dual Diagnosis

4.1. Dual diagnosis is a term used when a person experiences a mental health disorder and a problem with alcohol and/or drugs. It is possible that either the mental health disorder may have led to the substance use, or that the substance use may have led to, or worsened the person's mental illness.

4.2. Research published in 2008[5] obtained estimates of dual diagnosis prevalence rates across mental health and substance misuse services in Manchester. It established that the mean percentage of dual diagnosis clients throughout services was 46%. The highest proportions were identified in the assertive outreach team (71%), followed by substance use services (59%), and psychiatric inpatient wards (56%). The acute home treatment team (12%) reported the lowest estimate of clients with dual diagnosis problems. These estimates were considerably higher than previously reported prevalence rates.

4.3. Such research clearly suggests that there is a large cross-over of people who use substances and who experience mental health difficulties.

4.4. Currently the Manchester Dual Diagnosis Liaison Service offers specialist advice and consultancy to all practitioners within mental health and substance misuse services to support their work with services users who are Manchester residents and have a dual diagnosis. This can be delivered on trust premises or in community venues. It can be provided to practitioners alone or alternatively to practitioners with their client present (interactive 3-way session). The purpose of the Manchester Dual Diagnosis Service is to:

- Provide advice and consultancy to staff within mental health and substance misuse services to support their work with service users who experience both mental health problems and substance use problems.
- Deliver core skills and advanced skills training to staff within their mental health and substance misuse services to ensure practitioners are competent in the skills required to work with service users with a dual diagnosis
- Promote effective multi-agency work between mental health services and substance misuse services in Manchester.

4.5. This service is not currently available to practitioners supporting service users who are Bury residents but the Manchester community and inpatient lead is keen to widen the approach and liaison model. He is open to Bury professionals contacting him to explore how services can operate more closely together.

4.6. The origins of Michael's dual diagnosis remain unknown. However, whilst the co existence of drugs, alcohol and mental health created two support needs for Michael, it may be useful to think of him as an individual with 'complex' needs as opposed to an individual with two support needs.

5. Thematic Analysis

The exercise at 3.18 helped to identify key themes and underpinned the following thematic discussions.

5.1. Theme 1: Referrals and Assessments

[5] Dual diagnosis in Manchester, UK: practitioners' estimates of prevalence rates in mental health and substance misuse services: Mental Health and Substance Use: Vol 1, No 2 (tandfonline.com)

5.1.1. An effective referral is the beginning of an individual's path to recovery. The ensuing assessment is the first step in defining the person's needs regarding treatment and care.

Referral and Assessment under the Care Act 2014

5.1.2. Under the 2014 Care Act the Local Authority has a duty to carry out an assessment of anyone who appears to require care and support.

5.1.3. A referral to Bury Council must be made if after consideration, the following 3 criteria have been met:

1. A person has care and support needs and,
2. They may be experiencing or at risk of abuse and neglect and,
3. They are unable to protect themselves from abuse of neglect because of their care and support needs.

5.1.4. Upon receipt of a referral and upon becoming aware of an adult who meets the above criteria, the council must make or arrange an enquiry under Section 42 of the Care Act. These initial enquiries are carried out by Bury Council's Connect and Direct Hub.

5.1.5. The following table exhibits the referrals made to Bury Council's Connect and Direct Hub and the Adult Safeguarding Team regarding Michael throughout the scoping period:

Date	Circumstances	Action taken
January 2020	North West Ambulance Service attended Michael and because of concerns for Michael's alcoholism and him requesting assistance with his benefits forms, referred Michael to Bury Council's Connect and Direct Hub and requested an assessment	A customer advisor from the Connect and Direct Hub telephoned Michael and left a voicemail. Michael did not respond to the voicemail and his case was closed.
March 2020	Children's Social Care raised an adult safeguarding concern with the Bury Adult Safeguarding Team regarding Michael's alleged financial exploitation for drugs.	The safeguarding concern was closed as the team deemed Michael to not meet the Section 42(1) threshold (deemed not to have care and support needs).
April 2020	North West Ambulance Service referred Michael to Bury Council's Connect and Direct Hub reporting concerns for Michael's mental health, alcoholism, and ability to manage.	Michael was not seen, and the case was closed by the Connect and Direct Hub due to him having parental support from children's services. The children's support worker was asked to ascertain whether Michael consented to onward referrals to mental health support and Achieve.
June 2020	North West Ambulance Service and Children's Social Care raised further adult safeguarding concerns regarding Michael's self-neglect, suicidal ideation, exploitation (he had recently been robbed) and alcohol dependence.	The North West Ambulance Service referral was amalgamated with the above referral and the safeguarding team commenced Section 42 enquiries as per the concern received from Children's Social Care and made onward referrals to the Rapid Response Team before closing the case. A Care Act assessment was completed by Rapid Response who deemed criteria to be met.
August 2020	Police submitted a safeguarding concern to Bury Council's Connect and Direct Hub due to concerns of self harm.	The Connect and Direct hub discussed referrals to mental health and substance misuse services with Michael and he agreed for the referrals to be made. The case was closed.

November 2020	Children's Social Services raised concerns regarding self-neglect and exploitation to the Adult Safeguarding Team.	The Safeguarding Team made a referral for a Care Act assessment to the Integrated Neighbourhood Team and closed their Section 42 enquiry.
December 2020	North West Ambulance Service raised a safeguarding concern to Bury Council's Connect and Direct Hub regarding neglect and Michael not managing.	Bury Council's Connect and Direct Hub screened the referral and forwarded it to the Adult Safeguarding Team who referred into the Integrated Neighbourhood Team. At the end of January 2021, the Integrated Neighbourhood Team completed a Care Act Assessment.
February 2021	North West Ambulance Service referred Michael to Bury Council's Connect and Direct Hub citing concerns around suicidal ideation and alcohol dependency.	Bury Council's Connect and Direct Hub forwarded the referral to the Integrated Neighbourhood Team who linked it to their open case.
March 2021	North West Ambulance Service referred Michael to Bury Council's Connect and Direct Hub due to intoxication and Michael feeling suicidal.	Bury Council's Connect and Direct Hub forwarded the referral to the Integrated Neighbourhood Team who linked it to their open case.
March 2021	Michael contacted Bury Council's Connect and Direct Hub stating financial difficulty and no food.	Bury Council's Connect and Direct Hub forwarded the concerns to the Integrated Neighbourhood Team
April 2021	North West Ambulance Service referred Michael to Bury Council's Connect and Direct Hub stating Michael was suicidal and making threats to self-harm.	The Connect and Direct Hub referred the concern to the Integrated Neighbourhood Team who linked it to their open case.
April 2021	Michael contacted Bury Council's Connect and Direct Hub asking for help - he had no food or utilities and was experiencing suicidal ideation.	Bury Council's Connect and Direct Hub forwarded the concerns to the Integrated Neighbourhood Team
April 2021	North West Ambulance Service referred Michael to Bury Council's Connect and Direct Hub stating Michael was experiencing suicidal ideation, suffering chest pain, and was hallucinating.	Bury Council's Connect and Direct Hub forwarded the referral to the Integrated Neighbourhood Team who linked it to their open case.
April 2021	North West Ambulance Service referred Michael to Bury Council's Connect and Direct Hub stating Michael had no money and was suffering with his mental health.	Bury Council's Connect and Direct Hub forwarded the referral to the Integrated Neighbourhood Team who linked it to their open case.
April 2021	North West Ambulance Service referred Michael to Bury Council's Connect and Direct Hub stating Michael was intoxicated in public, unable to move and had overdosed earlier in the day.	Bury Council's Connect and Direct Hub forwarded the referral to the Integrated Neighbourhood Team who linked it to their open case.

5.1.6. In January 2020, no onward referrals were made to any mental health services or Achieve, and no referral was made for an assessment of Michael's care and support needs under the Care Act 2014. The Connect and Direct Hub have reported that the referral should not have been screened at customer advisor level and should have been screened by a professional/experienced worker to make decisions regarding any actions required.

Question 1 for BISP:
How can Senior managers in Adult Social Care reassure BISP that future referrals to Bury Connect and Direct Hub will be screened at the correct level?

5.1.7. In March 2020 the safeguarding team concluded that Michael did not meet the threshold for care and support needs and the concern was closed. Following exploration of this at the practitioner learning event, the adult Principal Social Worker met with managers for a debrief. A training need was identified where practitioners work in silo and do not use professional judgement, or speak to a more experienced colleague, before making the decision to close the referral. This is a learning action for Adult Social Care services who have acknowledged pathways for receiving and triaging possible Section 42 enquires requires updating.

5.1.8. In June 2020, the Rapid Response Team completed a needs assessment. Michael engaged with the assessment and allowed a worker entry to his flat. The assessment concluded that Michael required a personal assistant who could work with him to support him with laundry, tidying and completion of paperwork. He would also benefit from support attending appointments to enable him to engage with services. This assessment was a positive one with Michael engaging, but this review would ask whether its quality could have been enhanced through further discussion of Michael with his mother. It is recognised that Michael may have not agreed to this, but it is noted that there is no record on the assessment form of Michael verbalising that his information should not be shared with anyone in particular. In addition, this review has not seen any evidence of a personal assistant having contact with Michael, or an exploration as to why the support was not put in place.

5.1.9. In November 2020 the safeguarding team referred Michael to the Integrated Neighbourhood Team for assessment. This referral was closed by a member of the Integrated Neighbourhood Team (who was new in post) in error. The Integrated Neighbourhood Team, upon recognising the mistake, input the referral again but this was again closed in error. In January 2021 the safeguarding team questioned what had happened with the referral and upon review, the Integrated Neighbourhood Team input the referral for a third time and opened the case. A subsequent Care Act Assessment completed at the end of January 2021 demonstrated that Michael met the criteria.

Question 2 for BISP:
How can the Integrated Neighbourhood Team assure BISP that new staff, including managers, will be trained, and supervised effectively to prevent future referrals being closed inappropriately?

5.1.10. Further referrals received by the Connect and Direct Hub were referred to the Integrated Neighbourhood Team to be linked into their open Active Management Case. This was not appropriate as the Integrated Neighbourhood Team discusses individuals on a non-urgent basis. Better practice would have seen safeguarding/professionals' meetings convene to discuss any new concerns for Michael and decide whether any escalation was required. Active Management in the Integrated Neighbourhood Teams is not a substitute for a professionals' safeguarding meeting. This is discussed later in the report at section 5.2.

5.1.11. The referrals forwarded to the Integrated Neighbourhood Team that were linked to Active Case Management were mostly from North West Ambulance Service. North West Ambulance Service use one standard form to refer into Adult Social Care, no matter what the concern.

5.1.12. The police also use their own standard form for every concern. Therefore, a referral from the police or North West Ambulance Service does not differentiate at first glance whether it is a concern for welfare or a safeguarding concern. The Connect and Direct Hub can receive hundreds of these forms after a weekend and must screen them all to decide the right pathway and onward referrals for each referee.

5.1.13. Referrals from other agencies are by means of an online systemic referral form which is explicit with the categories of abuse highlighted. This makes for easier triage. (It should be noted that it was not until March 2020 that Social Workers joined the Connect and Direct team - prior to this call handlers triaged referrals.) Professionals have informed this review that it would be helpful if the ambulance and police service referrals were also explicit as to what category of safeguarding the referral is for. This would reduce Connect and Direct Hub workloads, improve the focus on safeguarding, and make for a more effective and accurate triage.

Question 3 for BISP:

How can Greater Manchester Police, North West Ambulance Services and Adult Social Care work to improve the referral system, and evidence improved efficiency to BISP?

5.1.14. At the learning event the review explored with professionals whether they identified any missed opportunities to refer Michael to the Local Authority and heard that overall, other professionals did not deem a safeguarding referral necessary as, whilst Michael was taking actions to end his life and reporting suicidal ideations whilst intoxicated, when sober Michael had no plans or intent. Therefore, professionals felt that there were no grounds at that time to raise a safeguarding adult alert as Michael was being referred into services to support him.

5.1.15. However, given Michael's presentation documented in June 2020 by the Greater Manchester Mental Health team as *poorly kempt, dirty clothes slightly too big* and *dirty hair and beard* it is possible that the threshold for a safeguarding investigation under the Care Act 2014 had been reached. At this point Greater Manchester Mental Health could have submitted a safeguarding concern.

5.1.16. Similarly in August 2020 the Mental Health Liaison Team identified in a Pennine Care Foundation trust risk assessment that due to ongoing drug and alcohol addiction, Michael's vulnerability and risk of exploitation was increased. A safeguarding referral could have been made at this time.

5.1.17. Whilst these two potential missed opportunities to refer were at a time when multiple other referrals were being made regarding Michael, it is important that all appropriate referrals are always executed. This ensures that safeguarding professionals are in possession of a full picture of the concerns.

5.1.18. The table at paragraph 5.1.5 evidences that Michael was assessed under the Care Act on two occasions. Both assessments provided professionals with some understanding of Michael's difficulties and needs. The problem was that moving forward, services struggled to engage Michael with the intervention deemed to support him.

5.1.19. On the occasions when an assessment was not deemed necessary, the safeguarding referral process was still helpful as Michael was referred into individual agencies as appropriate for support. The ongoing process being that these individual agencies would then undertake their own assessment of Michael's needs to focus their intervention and/or refer to other organisations considered helpful.

Referrals and Agency Assessment

5.1.20. In addition to the adult safeguarding process, Michael was brought to the attention of support agencies by means of referral from other professionals.

5.1.21. Michael had contact with the Mental Health Liaison Team on five occasions within the scoping period following suicidal presentations at A&E:

Date seen:	Onward Referrals to:	For:
February 2020	Home Based Treatment Team	Assessment
March 2020	Achieve	Alcohol and drug misuse support
June 2020	Clinical decision to admit to an Inpatient Mental Health Unit	Further assessment and bed sourced out of area.
December 2020	Home Based Treatment Team	Risk assessment and mental state examination
April 2021	Community Mental Health Team	Mental health assessment, care, And treatment in the community

5.1.22. The Mental Health Liaison Service based in the Hospital, assess people aged 16 and over who have presented in the Emergency Department and are experiencing problems with their mental health. Assessments from

this service focus upon the scope of substance misuse and onward referrals for inpatient admission, the Home-Based Treatment Team, Achieve and the Community Mental Health Team.

5.1.23. As per the above table, in March 2020 a referral was made by the Mental Health Liaison Team to Achieve. Achieve provides substance misuse treatment and recovery service. This review has also learned of referrals that were also made to Achieve by the Rapid Response Team in June 2020 and the Home-Based Treatment Team in December 2020.

5.1.24. Each referral was triaged and in line with the Greater Manchester Mental Health policy, assessment appointments were booked. Due to the covid pandemic, many of these appointments were telephone appointments. Michael did not answer the calls or respond to voicemails or letters asking him to make contact.

5.1.25. It was good practice that in July 2020 following ineffective telephone contacts, and concerns having been raised that Michael had presented in June 2020 as looking poorly kempt and dirty, an outreach visit from Achieve was arranged. Sadly, Michael did not answer the door and although a letter was left asking him to make contact, he did not.

5.1.26. Achieve did not ever have successful contact with Michael to complete their assessment.

5.1.27. The table further illustrates that the Mental Health Liaison Team did not make a referral for mental health support until June 2020. The fact that it was not made at earlier presentations when Michael was experiencing suicidal ideations suggests that initially, Michael's substance misuse was seen in isolation.

5.1.28. This is in line with a prevailing view that substance misuse needs to be treated before any psychological work. A Greater Manchester mental health lead has reflected that this is a common misconception, and that in most cases, the cause of an individual's mental distress can rarely be traced to either 'substance use' or 'mental illness'. In practice, they often coexist and occur exclusive of each other. It was good practice to refer Michael for substance support but referrals for mental health support could have been made at the same time.

5.1.29. Michael was referred to the Access and Crisis Team, which is the single point of access for all referrals into mental health services, on five occasions within the scoping period of this review:

Date:	Referrer:	Reason:	Action:
2nd September 2020	Adult Social Care	Adult Social Care had received five concerns regarding Michael in two months.	Achieve were informed and a letter was sent to Michael requesting that he contact the Access and Crisis Team for assessment.
17th September 2020	GP	Concerns about Michael's low mood and substance misuse	An appointment was sent to Michael, and it was agreed that a mental health practitioner would take the case to the Integrated Neighbourhood Team.
14th November 2020	Police	Care Assessment Plan referral (without Michael's consent)	GP contacted and asked to review Michael and refer into the Integrated Neighbourhood Team for further assessment if required.
1st April 2021	Police	Care Assessment Plan referral requesting a mental health assessment	Appointment sent to Michael offering a mental health assessment
5th April 2021	Police	Michael had contacted the police whilst feeling suicidal.	A decision was made to escort Michael to the emergency department of the hospital.

5.1.30.The Access and Crisis Team are an assessment and signposting service. They provide two core functions, referral management and mental health assessment. Assessments are offered via the telephone, video link or face-to-face at the Irwell Unit, but home visits can be facilitated where there is an identified need, and it is safe for staff to do so.

5.1.31.Several telephone appointments for assessment were offered to Michael and accepted. However, he continuously re-arranged them all, usually stating that his children were with him, and he was therefore unable to talk freely.

5.1.32.The Access and Crisis Team did not ever manage to complete an assessment with Michael either - meaning that despite professional attempts, Michael went unassessed both for mental health services and substance recovery whilst in the community.

5.1.33.Assessment was needed for more than just understanding the extent and nature of Michael's mental health and substance misuse. It was necessary to gather detailed information to gain an understanding of how his addictions and needs interacted with the other areas of his life[6]. A thorough and effective assessment would have allowed a treatment plan to be devised that was tailored to his individual needs and best supported him within his personal circumstances.

5.1.34.Michael had the right to not engage with this assessment process of his needs, but professionals had a duty to ensure that Michael had the mental capacity to understand the consequences of his decisions.

Mental Capacity Assessment

5.1.35.Under the Mental Capacity Act 2005, Michael had to be presumed to have capacity unless proved otherwise[7]. This review has not seen any documentation of any professional not assuming Michael to have capacity. To the contrary much agency documentation references Michael as having an ability to make his own informed choices unless under the influence of substances.

5.1.36.It is important to note that whilst many professionals at the learning event spoke of Michael as being 'assessed' to have mental capacity, professionals did not distinguish their 'consideration of Michael's capacity' from 'full assessment'. Whilst considering Michael's capacity rightly involved professionals asking themselves whether there was any reason to doubt his capacity - the absence of a reason should not have automatically concluded that assessment was not necessary.

5.1.37.There have been recent proposed changes[8] to the Mental Capacity Act Code of Practice which include distinguishing between considering and assessing capacity.

5.1.38.Instead of assuming capacity, professionals attempting to support Michael could have afforded Michael's substance-related fluctuating capacity, further critical reflection, and ruminated on how substance use affected his ability to make his repeated day-to-day decisions such as managing his addictions and safeguarding his finances.

5.1.39.In 2019 The Alcohol Change UK report, 'Learning from tragedies[9]', analysed 10 Safeguarding Adult Reviews and one independent safeguarding review where alcohol was relevant to the death of the individual. The reviews that were studied identified challenges assessing capacity where a person (like Michael) would usually have the ability to make decisions, but not when intoxicated.

[6] The review explores whether in the absence of Michael's engagement, information could have been sought from other sources, at section 5.4

[7] The new draft code of practice includes new text covering the assumption of capacity. In several places, for example, it emphasises that assuming capacity should not be used as a reason for not assessing capacity. If there is a "proper reason" to doubt that the person lacks capacity, an assessment is necessary

[8] The draft Mental Capacity Act Code of Practice was published for public consultation on the 17th of March 2022. Consultation ended on the 14th of July 2022.

[9] Learning from tragedies: an analysis of alcohol-related Safeguarding Adult Reviews published in 2017 | Alcohol Change UK

5.1.40. These issues were linked to the quality of statutory guidance[10] on the Mental Capacity Act available to practitioners as the guidance does not address alcohol use - other than to point out that a temporary lack of capacity may be caused by the effects of alcohol.

5.1.41. The study points out that the *guidance suggests that if it is thought a person will be able to regain capacity at a later point, and if it is practical, then the assessor should wait to assess capacity. However, this is challenging if an individual continually moves in and out of capacity due to intoxication or spends the majority of their waking hours intoxicated with some moments of lucidity. It is this dynamic that limits the application of the Act to people with alcohol problems*.

5.1.42. One of the reviews considered within the study had noted that, *when a person is a chronic alcohol user it could be argued that they are never sober. More so that their ability to reason about whether they want to stop drinking is significantly impaired due to the addictive nature of their alcohol use.* The same review questioned; *is someone who is a chronic alcohol user ever in a space where their addiction is not impacting on their ability to reason?*

5.1.43. In agreement, this review would ask, was Michael, in the latter time of his life, ever able to make decisions independent from substance influence?

5.1.44. As previously mentioned, there have been recent proposed changes to the code of practice, and these include updated guidance on fluctuating capacity. The draft code notes that, for repeated decisions it may be appropriate to consider the broader time over which the decisions need to be made. This is especially so if the consequences of the decisions are serious, and the person only has capacity to make them for a very small part of the time.

Question 4 for BISP:
How can partner agencies assure BISP that their professionals understand changes to the Mental Capacity Act Code of Practice and learn how to apply the act to people whose capacity may fluctuate? For example, those with substance misuse problems.

5.1.45. Further critical reflection of Michael's capacity to engage with services may also have recognised that Michael appeared to have had the ability to understand the consequences of a decision but lacked the performative ability to execute the choice. This in turn may have prompted consideration of decisional and executive capacity which is discussed further in this report at section 5.3.

5.1.46. Michael's brain injury may also have had an impact on his ability to make decisions. During the recovery process of such an injury, cognitive problems can make it impossible for brain injury survivors to understand the consequences of their decisions. This review has seen no evidence of professional exploration into how Michael's brain injury may have affected his capacity.

Police Referral

5.1.47. Since the scoping period of this review the College of Policing has published new guidelines[11] which provide a framework to ensure Adults at Risk receive the appropriate help during interactions with the police. However, it is clearly recorded that the Officers attending Michael recognised his vulnerability.

5.1.48. The police responded to several incidents within the scoping period of this review. Some attendances were when Michael was in crisis whilst others were at the request of agencies requiring police assistance. In addition, police attended Michael when he had been reported as either a victim, or a perpetrator of a crime.

5.1.49. Michael didn't support any investigation into any crimes that he reported and at times he was aggressive towards Police Officers. Despite the sometimes-adverse reaction to the Officers, there is no evidence or

[10] Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)
[11] Vulnerability-related risks | College of Policing

suggestion that Officers treated Michael any differently to any other member of the public. Nevertheless, Michael's inability to engage with the police service resulted in crimes not always being fully explored and reduced Officers ability to fully assess Michael's vulnerabilities and exposure to financial exploitation[12].

5.1.50. Despite this, in line with the Vulnerability Assessment Framework for Adults, multiple care plans were generated by Officers who had attended Michael, and referrals were frequently made to supporting agencies such as Adult Social Care and Mental Health services. There is evidence of Officers making referrals to external agencies despite Michael stating that he did not give his consent to share his information. On such occasions Officers overrode his consent and shared the care plan information in Michael's best interests in line with the Adults at Risk Policy 2020.

5.1.51. This review would conclude that multiple appropriate referrals were made by professionals on behalf of Michael to attempt to provide him with care and support, but the subsequent required assessment was hindered because professionals were unable to engage Michael.

5.2. Theme 2: Integrated Neighbourhood Teams

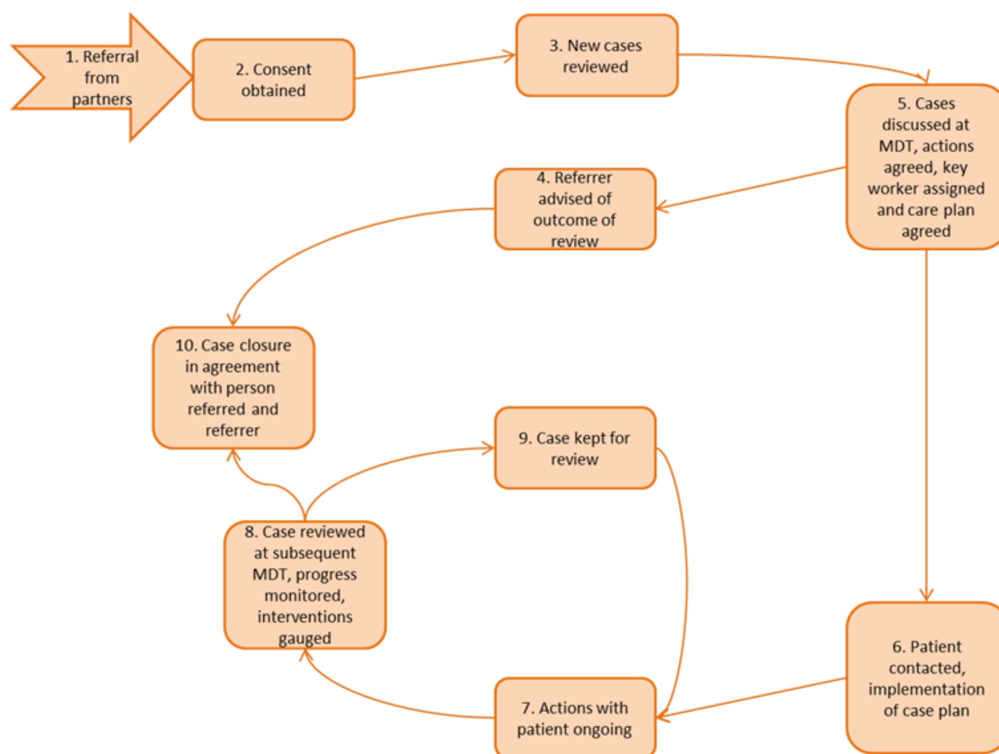
5.2.1. The Integrated Neighbourhood Team, which helps to coordinate health and social care services, is made up of District Nurses, Social Workers, GPs, and people from the voluntary sector. Within the Integrated Neighbourhood Team is 'Active Case Management'. Active Case Management is the identification of people at risk of going into hospital or residential care, who can be supported to improve their health and wellbeing. Michael with his complex needs and high usage of services, was fitting for Active Case Management.

5.2.2. On the 23rd of August 2020 the Access and Crisis Team emailed the Integrated Neighbourhood Team Practitioners to request that Michael was discussed for multi-disciplinary input given the sporadic engagement and amount of concern being raised. The Integrated Neighbourhood Team responded, requesting that Michael's consent be sought in the first instance.

5.2.3. Michael was then referred into Active Case Management in September 2020 by Bury Adult Services who had been unable to gain his consent but had overridden this due to the nature of the concerns. The referral highlighted that 'Michael did not engage with services' and noted that a multi-disciplinary team approach was required due to Michael's complex needs regarding substances, mental health, Chronic Obstructive Pulmonary Disease and reported incontinence.

5.2.4. Michael's case followed the programme model, and he was discussed in a virtual multi disciplinary team meeting where it was decided that Michael's GP would be the key worker and would arrange a consultation with Michael and offer support. (Sandra has told this review how grateful she is to Michael's GP for her attempts to see Michael and support him; whilst there is no record in GP case notes - Michael told Sandra of a time when the GP had been waiting for him outside the pharmacist, having learned that he was there.)

[12] Following Michael's death, the police investigation team found no evidence of financial exploitation.



5.2.5. From hereon Michael was discussed at the Integrated Neighbourhood Team meeting every four weeks. There is evidence of much discussion in meetings regarding appointments that Michael had not attended, and services he had declined, but only one record of a solution to overcome such declination; It was good practice that in November 2020, Michael's GP decided a new approach to facilitate a contact with him; that being that his prescription would no longer be prescribed on a Wednesday, thus Michael would have to go into the GP practice on a Thursday enabling the GP to see him.

5.2.6. Professionals at the learning event informed this review that Active Case Management stayed open to Michael because 'he was not engaging with services' but there is no evidence of this being considered as a safeguarding concern.

5.2.7. It is notable that there is no advise or protocol in the 'Integrated Neighbourhood Team Standard Operating Procedure' of what to do if services are continually unable to engage a subject of Active Case Management. Services inability to engage Michael should have been considered as a safeguarding concern in itself, and a referral should have been made to the Local Authority safeguarding team to address it under the correct safeguarding procedures.

5.2.8. In turn, staff from the Connect and Direct Hub need to understand that a person is not precluded from safeguarding criteria because they are subject to Active Case Management and that the two processes (Active Case Management and Safeguarding) can run parallel. Returning a person's case to the Integrated Neighbourhood Team's Active Case Management hides a chain of concerns which can be used to monitor a person's deterioration of circumstances and/or risk level.

5.2.9. Documentations evidence that many professionals fed information into the Active Case Management process. This information sharing is good practice, but the Active Case Management is a monitoring and review forum. Forwarding concerns to Active Case Management and bypassing safeguarding procedures is dangerous as it downgrades professional response.

5.2.10. Correct use of the Active Case Management would include a professional checking for example, an individual's medication, or referral. Active Case Management is a place to find out which other agencies are involved with a person, what their findings are, and to explore ideas. As previously mentioned at paragraph 5.1.10, the Active Case Management discusses individuals on a non urgent basis and does not replace any

safeguarding/professionals' meetings that should convene due to any required escalation or because of new concerns for a person.

5.2.11. This review would respectfully ask whether professionals may be over reliant upon the Integrated Neighbourhood Team when they know that a case is under Active Case Management.

Question 5 for BISP:
How can BISP explore and address whether professionals from all agencies:

- **Are becoming over reliant upon the Integrated Neighbourhood Team when they know that a case is under Active Case Management,**
- **Understand that the Active Case Management pathway is not a substitute for Safeguarding Pathways and that the two can run parallel?**

5.2.12. The review panel identified that the issue of forwarding concerns to current workers involved with a person instead of making a safeguarding referral is not unique to Active Case Management. For example, often if a person has a Mental Health Care Coordinator and a new concern arises, a professional will only contact the Care Coordinator. Better practice would see a safeguarding referral being completed *and* the Care Coordinator being updated.

5.3. Theme 3: Executive Functioning

5.3.1. Executive functioning is a set of mental skills that helps a person to get things done. These skills are controlled by an area of the brain called the frontal lobe. When executive functioning isn't working as it should, a person's behaviour is less controlled, and they are less focussed.

5.3.2. Executive functioning can be divided into two groups: organisation (collecting information and arranging it for assessment) and regulation (changing behaviour response in accordance with the environment).

5.3.3. For example, in Michael's case, when he thought about, or saw a drink of alcohol and found it tempting, he needed the organisational part of his executive functioning to interrupt and tell him that drinking the alcohol conflicted with his goal of being sober.

5.3.4. Upon recognising that Michael would agree to actions which would address his addiction and poor mental health, but then repeatedly struggled to execute the actions, professionals working with him could have suspected problems with his executive functioning.

5.3.5. There is no formal diagnosis, or medication to correct weak executive functioning but had tests suggested that Michael was experiencing it, behaviour therapy and cognitive behavioural therapy could have been explored to improve his decision-making capacity. However, it is recognised that such therapy would have been dependent upon Michael's ability to engage, and this is explored in the next section of this report.

5.3.6. Whether Michael would have engaged with any therapy or not, it would have been helpful for professionals to establish whether he was experiencing weak executive functioning as (whilst executive functioning problems alone are not evidence of a lack of capacity), it could have affected Michael's mental capacity.

5.3.7. As previously mentioned, agency documentation evidence that professionals considered Michael to have the mental capacity to make his own decisions but professionals assessing the capacity of a person with weak executive functioning must remain alert to the fact that such people can present very well in formal assessment of cognition and capacity but are unable to carry out their intentions.

5.3.8. This leads the review to consider the term executive capacity.

5.3.9.In 2010 the authors (Naik, A et al) of the paper; *Patient autonomy for the management of chronic conditions: A two-component re-conceptualization*[13], summarised 'executive capacity' and wrote:

> *The clinical application of the concept of patient autonomy has centred on the ability to deliberate and make treatment decisions (decisional autonomy) to the virtual exclusion of the capacity to execute the treatment plan (executive autonomy) … Adherence to complex treatments commonly breaks down when patients have functional, educational, and cognitive barriers that impair their capacity to plan, sequence, and carry out tasks associated with chronic care. …* [Therefore] *assessment of capacity for patients with chronic conditions should be expanded to include both autonomous decision making and autonomous execution of the agreed-upon treatment plan.*

5.3.10.The 2011 Social Care Institute for Excellence paper *Self-neglect and adult safeguarding: findings from research*[14] (Braye, S; Orr, D; and Preston-Shoot, M) further highlighted executive capacity and the aforementioned draft Mental Capacity Act Code of Practice now has new guidance. The draft code confirms that if the person cannot understand (and/or use and weigh) the fact that there is a mismatch between what they say and what they do when required to act, it can be said that they lack capacity to make the decision in question. However, this conclusion can only properly be reached when there is clear evidence of repeated mismatch, and a single assessment is unlikely to be adequate.

5.3.11.In the case of Michael his mental capacity was considered by several professionals over a period of time. But professionals only asked whether there was any proper reason to doubt his capacity to make a decision. Michael's inability to execute any actions, for example, attend an appointment he had agreed to or engage with an assessment, went unconnected to his capacity. True assessment of Michael's capacity required him to both inform the professional of how he would make an informed decision, and also demonstrate this in practice.

Question 6 for BISP:
How can BISP be reassured that professionals from all agencies are aware of executive functioning and able to confidently consider a person's executive capacity within capacity assessment?

5.4. Theme 4: Hard to Reach Service User

5.4.1.The table at 3.18 shows that the main barrier to Michael receiving supportive intervention was professionals' inability to consistently engage him with a service.

5.4.2.As already explored within this report, the inability of services such as the Home Treatment Team, the Access and Crisis Team, and Achieve, to engage Michael resulted in ineffective referrals as professionals were unable to complete an assessment of his needs. And consequently, unable to gain an understanding of Michael's care and support requirements in totality.

5.4.3.In December 2020 following 17 contact attempts since January 2020, the Home Treatment Team discharged Michael from their service. The discharge was in line with their Admission Avoidance Pathway which states that the individual must agree to engage with services, and in line with their Did Not Attend / No Access / No Engagement policy, was shared with Michael's Social Worker, safeguarding teams within the Local Authority, and Achieve.

5.4.4.The Access and Crisis Team similarly liaised with various partner agencies when Michael did not accept their services, but records reflect that in addition they considered whether it was necessary to escalate the case to the police for a Concern for Welfare or Mental Health Act Assessment. Although it was decided unnecessary as Michael was in regular contact with the service and denying that he had thoughts to harm himself or others, this was good practice.

[13] Patient Autonomy for the Management of Chronic Conditions: A Two-Component Re-conceptualization - PMC (nih.gov)
[14] SCIE Report 46: Self-neglect and adult safeguarding: findings from research

5.4.5. In total there were five referrals to Achieve during the scoping period of this review, but each referral was closed due to no engagement. However, it was good practice that in July 2020 following ineffective telephone contacts, and concerns having been raised that Michael had presented in June 2020 as looking poorly kempt and dirty, an outreach visit from Achieve was arranged. Sadly, Michael did not answer the door and although a letter was left asking him to make contact, he did not.

5.4.6. All the discharges were in line with service policies but service's inability to engage Michael presented a risk to Michael in itself. This safeguarding concern was overlooked by agencies discharging him from their service who did not escalate the failed engagement as a concern.

5.4.7. The review has identified language such as *he's not helping himself* in professional case notes. Such language could indicate a subtle unconscious bias towards a person who struggles to engage. This concept is likely an uncomfortable one for workers and managers alike, but unconscious bias is by its nature, impossible to see past without the support of others suggesting it. Everyone has biases that they are unaware of, but that shape their decisions. Influences such as a heavy workload, could unconsciously sway a professional's decision to accept that they cannot engage a person, rather than work to understand and achieve.

5.4.8. In addition, the language label 'non-engagement', or the term 'does not engage' can contribute to creating a professional unconscious bias of a person who is not going to engage. Such labels can close minds and because a label is often seen before the person, once a label is attached to a person - it is in danger of defining the professional's journey with that person in advance. It can then be used as an excuse for, in the case of Michael, any failure to make contact.

5.4.9. The continued use of labels which describe a person, who services have been unable to engage, as a non-engager, contrasts with any person-centred, strengths-based approach and needs to change.

5.4.10. Current labels apportion blame; the term non-engagement suggests that Michael deliberately wasn't in when professionals attended his addressed (whether he knew they were coming or not) or didn't reply to a letter or voicemail (whether he ever received it or not and/or was in a sober state to read/listen and understand).

Question 7 for BISP:
How can BISP work with partner agencies to change the use of labels (for example 'does not engage') that are in danger of apportioning blame and contrast with a person-centred, strengths-based approach.

5.4.11. Whilst this review has not seen any documentation which would suggest that services' difficulties engaging Michael swayed any practitioner into making any different decisions around ongoing support, referrals or discharge protocols, more professional curiosity and reflection as to why services struggled to engage Michael in assessment and/or appointments/treatments, despite him saying that he wanted to reduce his reliance upon substances, may have provoked a more robust response and encouraged tailored intervention.

5.4.12. The key to engagement and support, is to build up a relationship of trust and within that relationship to try and understand how the person got into the position they are in. Professionals at the learning event recognised that this relationship building was possible with Michael as it had been achieved by an Early Break worker in February 2020. Whilst his engagement with the worker remained on his terms – it is clear from discussions with professionals at the learning event that Michael felt confident to liaise with this worker and contact her.

5.4.13. The review has also heard that Michael's GP managed to build a rapport with Michael and instigate meetings, despite him sometimes being verbally aggressive with staff. Due to behavioural concerns, Michael's relationship with his previous GP had broken down and he was de-registered from the surgery. The good practice exampled by Michael's new GP should be shared with all Primary Care colleagues so the learning can be embedded to recognise adults at risk who are displaying behavioural challenges

5.4.14. Whilst practices have the right to end a patient-doctor relationship that isn't working, the British Medical Association states that removal of a patient from a GP practice list should be rare[15]. The British Medical Association advises that many patients can change their behaviour if it is brought to their attention, however it does recognise that if all else fails - it is not in the best interest of either the patient or staff at the surgery to continue with the relationship.

5.4.15. Some insight into the obstacles services faced engaging Michael is gleamed from the Adult Care Assessment undertaken in January 2021 when Michael discloses that he is *very embarrassed to accept help*. This would suggest that Michael felt stigmatised by his substance misuse and/or mental health problems and its effects.

5.4.16. A report: Sinning and Sinned Against: The Stigmatisation of Problem Drug Users[16], written by Charlie Lloyd, aims to review research relating to the stigmatisation of problem drug users. It was published in 2010 by the UK Drug Policy Commission and funded by the Paul Hamlyn Foundation, the Scottish Drug Recovery Consortium, and the Esmée Fairbairn Foundation.

5.4.17. Lloyd notes the negative effect that words often favoured by society and the media, such as 'junkie' or 'abuser', have on the perception of society in general, and the knock-on effect it can produce.

5.4.18. A key aim of the report is to examine whether stigma itself acts as a barrier to rehabilitation and it concludes that *problem drug users are a very strongly stigmatised group, and this has a profound effect on their lives, including their ability to escape addiction*. Lloyd suggests that stigma can be addressed, through language, education, increased contact between people who have trouble controlling their use of substances and the public, a more respectful approach from the police, targeted campaigns (as seen in the United States) and the management of physical signs of stigma, such as the removal of needle marks. Importantly, the report recommends that research is required about the influence of stigma on the availability of support services; for example, the experience of stigma while collecting medication in pharmacies, and discrimination experienced from services such as housing or employment following recovery.

5.4.19. Despite his embarrassment there were times when Michael would attempt to engage with services and consequently there were small windows of opportunity to gain Michael's trust. For example, in April 2021, Michael contacted the Patient, Advice and Liaison Service[17] reporting to be feeling suicidal. The service referred Michael to the Alcohol Liaison team but when an alcohol liaison practitioner spoke with Michael via the telephone (which he did on three occasions) he was unable to engage Michael with any treatment plans offered.

5.4.20. This review has not seen any transcript of initial conversations between professionals and Michael but would encourage that a strengths-based approach is utilised. In their guides to strengths-based questions and strategies for engagement, Mel Gray and Leanne Schubert from the University of Newcastle in Australia suggest the following:

5.4.21. *At the outset of assessment avoid questions like:*

- *How can I help you?*
- *What problems bring you in today?*
- *What led to you being referred for assessment?*

5.4.22. *A more strengths-based approach to opening questions include:*

- *What do you want to accomplish during our conversation today?*
- *What concerns of yours do you want to address and change as a result of this assessment?*

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[15] Removing patients from your GP practice list (bma.org.uk)
[16] Microsoft Word - Stigma_Expert_Commentary_final2 (ukdpc.org.uk)
[17] The Patient Advice and Liaison Service (PALS) offers confidential advice, support, and information on health-related matters. They provide a point of contact for patients, their families, and their carers.

- *What can we work on together to achieve what you want for your life (and that of your carer or family)?*
- *What are you wanting for yourself right now?*
- *What is important for us to speak about today that will help me appreciate your circumstances and to learn about you, your abilities, your strengths, your preferences, and hopes for your life?*

5.4.23.*Beginning an assessment with engagement and relationship building invites curiosity regarding the person being assessed. It is important to acknowledge that individuals in need of care continue to hold many strengths and retain capacities for learning, growth, and change. Ask yourself what makes this person unique and seek to uncover the answers to this question.*
Expand these beginning questions with questions that encourage deeper exploration:
- *What are the things that are working well in your life?*
- *What aspirations and hopes do you have for the coming days, weeks, months, or years in relation to your circumstances and needs?*
- *What is it that helps you get by when things are difficult?*

5.4.24.In the event of services still being unable to engage Michael, the question that this review would respectfully pose to all professionals working to assess and support Michael is *Could services' inability to engage Michael have been escalated as a safeguarding concern?* Rather than just acknowledge and share that engagement has not been achieved, should professionals be asking themselves, *what more can I do to safeguard this person?*

5.4.25.One avenue that could have been considered was self-neglect in the context of non-engagement. This would have allowed the progression of an Adult Safeguarding Referral with services inability to engage Michael at the forefront of assessment and multi-agency planning[18].

5.4.26.Alcohol Concern works with Local Authorities on a scheme known as the Blue Light Project[19] which seeks to support hard-to-reach drinkers such as Michael who fit into three criteria:
- Alcohol dependent
- Burden on public services
- Non-engagement with treatment

The Blue Light project *challenges the belief that only drinkers who show clear motivation to change can be helped* and they provide courses to support the development of more effective working with people with co-occurring conditions and complex needs. Could agencies benefit from a proportionate number of staff utilising the programme and developing a specialism which could be used to further support colleagues?

Question 8 for BISP:
How can BISP develop practice with all partner agencies which will:
- **make services more inclusive for hard-to-reach people,**
- **learn from examples of best practice, and**
- **ensure that decisions to close a case in all agencies due to not being able to engage with a service user, are subject to robust supervision discussion?**

5.5. Theme 5: Family and Community

5.5.1. Discussion was had at the learning event as to whether Michael's family and community could have been utilised in the assessment of Michael's needs and to inform professionals of any fluctuation of Michael's risk of harm.

[18] The self-neglect and hoarding strategy is undergoing a review to ensure it is robust and fit for purpose, training is also being sourced to support roll out of the strategy when this is ready.
[19] The Blue Light Project | Alcohol Change UK

5.5.2. The review has been informed by professionals that Michael declined for professionals to contact his mother, but has not seen any documentation of his reasons, or evidence of any exploration had by practitioners to understand why.

5.5.3. Benefits of professionals speaking with Sandra were to be had; Sandra would have been able to furnish professionals with some of Michael's background, including historic responses to rehabilitation programmes, which may have helped them to understand his patterns and behaviours, and importantly Sandra could have told professionals of what support she had offered, and was still able to offer Michael. In addition, this review has heard from Sandra of.

- occasions when she recognised a deterioration in Michael's presentation,
- many incidents whereby Michael had told her of people taking money from his bank account, and
- actions she had considered, such as applying for Power of Attorney of his finances.

An open communication between professionals and Sandra would have facilitated a transfer of such information and debate/encouragement of ideas of support.

5.5.4. Michael created for professionals a picture of him leading an isolated life. Consequently, Michael's circumstances were seen as his, and insufficient attention was paid to the threat his behaviours potentially posed to others, particularly his children.

5.5.5. Many professionals were aware that Michael had children but knowing that the children did not live with him, did not always consider how his actions could affect them. For example, the impact of Michael's mental health on his children is not referenced within case notes completed by the Mental Health Liaison Team or the Home Treatment Team despite several references made to Michael's children's circumstances.

5.5.6. The corelations and interconnections between family members mean that what happens to one affects everyone else, and for this reason it is imperative that all professionals take a Whole Family approach. Traditionally the Whole Family approach was in relation to identifying caring roles within a family, but the approach is about much more than that; because of one family members circumstances, other family members may need support.

5.5.7. For example, was consideration given to Michael's children keeping safe when visiting their father's address when Michael presented under the influence of substances and/or suicidal? This review has heard of domestic incidents occurring between Michael and his son. Both parties have been identified as the victim and the perpetrator on different occasions but Michael being under the influence of substances has been a recurring factor.

5.5.8. A Whole Family approach appears to have been considered by the Active Case Management team as the case notes from the meetings reference that deliberation was had regarding risk to others. However, the notes conclude that whilst professionals knew that Michael had children who he had some contact with, there was no risk as Michael lived on his own.

5.5.9. Whilst it may have been true that Michael lived alone, Michael's children were able to visit his flat and he was having contact with them. This review has been informed that at times Michael told professionals that his contact with his children was limited, or had stopped, but even if such a statement was true when he said it – his circumstances fluctuated and his contact with his children was open to change. Professionals should always err on caution in such circumstances and demonstrate respectful uncertainty. In other words, professionals should always take a robust approach to safeguarding and guard against misleading or false information by 'checking out' information with other sources.

5.5.10. This information sharing within the Whole Family approach is a two-way communication method and it needed professionals working with members of Michael's family to offer the same consideration and inform of any family influences that could affect Michael. It is clear that professionals working with Michael's children knew of Michael as he was included in meetings discussing their welfare. Having recognised that Michael had his own problems, professionals could have ensured that Adult Social Care was made aware when any significant incidents occurred around the children, which may have caused Michael additional stress.

5.5.11. Contrariwise, there is no evidence of a whole family approach at any of Michael's emergency department presentations regarding information around a significant incident concerning Michael being shared with children's services, even though Michael mentioned his children on several occasions.

5.5.12. However, it has been brought to the attention of this review that a member of the mental health liaison team did ask Michael if contact could be had with Sandra. Sadly, Michael declined. Whilst this is an example of good practice, better practice would have seen documentation to evidence that a practitioner had attempted to discuss and explore Michael's reasons to declining contact.

Question 9 for BISP:
How can agencies and organisations assure BISP that professionals are being reminded to take a holistic 'Whole Family' approach when considering an Adult at Risk, and how can Children's Social Care and Adult's Social Care assure BISP of a 'Whole Family' approach which encompasses efficient information sharing and affords both agencies best visibility of a service users' circumstances.

5.5.13. A more respectfully uncertain approach combined with professional curiosity could have helped professionals develop a better understanding of Michael's position in his community. For example, a professional curious worker, upon Michael often reporting to need a food parcel could have further questioned where Michael's money was going and assessed Michael's wider appearance. Particularly when he was in receipt of injuries or seemed to be hiding something.

5.5.14. Sandra has told this review of many occasions when Michael told her of 'friends' emptying his bank account, or of using his card to purchase online items for themselves. Michael admitted to giving his 'friends' his Personal Identification Number and asking them to withdraw money on his behalf.

5.5.15. Michael did not recognise himself as a victim of exploitation as he considered the people who were taking his money to be his friends, but the truth is that Adults at Risk are not just exploited by strangers. In addition, Michael's failure to recognise his own exploitation, and his continual disclosure of his bank card's Personal Identification Number, despite his mother reminding him not to, left Sandra feeling powerless.

5.5.16. Empowering members of our communities to share concerns they may have about a family member or a friend who they worry is being exploited, could help, and is considered later in this section of this report.

5.5.17. There were some indicators of exploitation to professionals; In January 2020 police received a report of a 'theft from dwelling' by an ex-partner of Michael's and learned of his bank card having been subsequently used for transactions. On this occasion police note that Michael did not wish to pursue any prosecution as the bank reimbursed the sum of money. There was then another theft of Michael's bank card reported but, on this occasion, no indication that money had been stolen from the bank account. Both reports were recorded as crimes by Greater Manchester Police but were dealt with in isolation and not considered with any holistic regard of Michael's vulnerabilities[20].

5.5.18. February 2021 has seen the introduction of the THRIVE risk assessment framework to Greater Manchester Police. The framework is aimed at supporting staff in the Operational Communications Branch[21] to better identify vulnerability, threat, harm, and risk within open incidents. The THRIVE training enables every call made to Greater Manchester Police to be endorsed with a comprehensive risk assessment at that very first point of contact which includes consideration of Vulnerability. The call handler will consider whether the person is vulnerable, and whether because of their situation or circumstances, they are unable to take care of themselves or protect themselves or others from harm or exploitation.

[20] As previously stated, following Michael's death, the police found no evidence of financial exploitation.
[21] This is now referred to as the Force Contact Centre.

5.5.19.In addition, the ambulance service was called to Michael in August 2020 after Michael had been chased by teenagers and fallen over. This incident was not attended by the police. There was no exploration as to whether there was more to the incident in terms of abuse or exploitation to Michael.

5.5.20.Similarly, Michael's GP was informed in March 2021 by the Emergency Department at the hospital that Michael had attended with bruises, abrasions and swelling to his face. A few days later a Social Worker informed of a neck injury, and at the end of the month Michael telephoned the GP surgery and advised of a fall which had resulted in a head injury. Consideration could have been had of sharing with other agencies that there had been three reports of physical injuries within one month.

5.5.21.On the day that Michael was found deceased in his flat, neighbours, concerned because they hadn't seen him for a while, had looked through his window and eventually forced entry. The same neighbours later told police that when they had last seen Michael, he had confided in them that he was being financially exploited by two males. This scenario evidences two details; firstly, members of Michael's community were sufficiently concerned about him to check on his welfare after he wasn't seen for a period of two days. And secondly, Michael had been concerned about financial exploitation and confided in some people. The resultant question is therefore, why didn't any members of Michael's community raise any concerns for Michael?

5.5.22.During September 2018 until the end of February 2019 the Cambridgeshire and Peterborough Safeguarding Adult Board held a survey to find out what the public knew about safeguarding adults at risk. The survey was accessible via easy read surveys and electronic surveys (Survey Monkey) and all the 122 members of the public responses were anonymous. The question 'if you had concerns that an adult was being abused or neglected would you report it, was posed. A resounding 100% of respondents to the question stated that they would. However, interestingly 29 people skipped the question. To the question 'If you thought that an adult was at risk of abuse or neglect and you decided that you would report it, where/who would you report this to?' 32% stated that they would contact Adult Social Care, followed by; the Safeguarding Adults Board (18%), police (10%), a carer/support worker (8%), 5% would tell a general practitioner/nurse, 2% family/friend and one person 'did not know'.

5.5.23.The survey didn't address how well the public recognised self-neglect as a concern, or substance dependency, but it demonstrates how unclear the public are on what to do with concerns. It is interesting that of the respondents, 89% said they had heard of the term safeguarding and 50% said that this was from a safeguarding training event or conference. This would suggest that these people may have worked within the safeguarding arena rather than learned about safeguarding through any promotion the safeguarding boards may have done with the public.

Question 10 for BISP:
How can BISP promote/explore whether members of the public understand 'what safeguarding is' and ensure that members of the public know who to contact with concerns about any Adult at Risk?

5.6. Theme 6: The Effects of the Covid Pandemic

5.6.1.In December 2019 a coronavirus emerged which was rapidly identified as pandemic. As a result, the United Kingdom saw the Prime Minister announcing a national lockdown on the 23rd of March 2020.

5.6.2.As a consequence, professionals had to rapidly adapt to new working conditions. The second phase of a UK wide study[22] exploring the impact of the covid-19 pandemic on health and social care has highlighted that social work and nursing were the most impacted occupational groups.

[22] HSC Workforce Study

5.6.3. Amongst the confusion of the new conditions, professionals whilst concerned for the safety of those around them, were understandably also concerned for their own safety. Everyone worked hard to maintain service and continuity for their patients and service users, but no one could escape the emotional distraction that the pandemic introduced.

5.6.4. Over time, practices and communications within the new working conditions have become more effective and the ability of staff to adapt is praiseworthy, but this review must look at how covid affected the support afforded to Michael with his health and dual diagnosis.

5.6.5. This review has heard that:

5.6.5.1. North Manchester Mental Health Liaison Service continued to function as per service specification throughout the pandemic and that Michael was triaged, assessed, and treated in line with Greater Manchester Mental Health timeframe expectations.

5.6.5.2. Achieve offered telephone assessments which were in line with Greater Manchester Mental Health covid risk assessments and working arrangements during the pandemic. A face-to-face assessment was arranged and took place after Michael did not answer telephone assessment.

5.6.5.3. Similarly, the Access and Crisis Team and the Alcohol Liaison Team held telephone assessments. Although the Access and Crisis Team would have seen Michael face-to-face had Michael requested.

5.6.5.4. Michael was seen face-to-face when presenting to the hospital Emergency Department and the Home Treatment Team offered face-to-face contact within the Irwell unit or at home.

5.6.5.5. The GP practice mainly contacted Michael through telephone consultations during covid, but face-to-face appointments were arranged where deemed necessary and the GP abetted such appointments when necessary.

5.6.6. As is widely known, the pandemic has put the NHS under extreme pressure. The Emergency Department at the hospital, whilst utilising agency staff to manage staff absences, saw an increase in the amount of people attending. Likely because people were struggling to visit their GP surgery. It is therefore commendable that Michael's experience of the Emergency Department does not appear to have been affected.

5.6.7. Concerning Michael's contact with police, when police logs were generated, there was a covid consideration listed on each incident log stating, "Is there anybody at the address/location self-isolating or showing symptoms of covid? Please provide details for the attending officer/s". There are no such indications that covid was prevalent in any of the individual incidents involving Michael. Greater Manchester Police operated a business-as-usual approach during the pandemic but there may have been additional resourcing pressures due to staff absences. There is no conclusion that any police responses to Michael or police service offered was affected by covid.

5.6.8. Even as the lockdown restrictions lifted, covid continued to stifle professionals' ability to engage face-to-face with Michael. For example, Michael held a sole tenancy with Six Town Housing throughout the scoping period of this review. During the covid pandemic when contact was attempted by housing officers, Michael deferred contact due to stating he was feeling unwell or isolating, consequently his property was not inspected.

5.6.9. Possibly the most significant issue regarding the pandemic was its personal effects upon Michael. Sandra has informed this review that Michael often told her that he was struggling with the effects of the covid restrictions. Sandra has described Michael as someone who needed the company of others and she knows that even during lockdown Michael was socialising to some extent with his 'friends' and was going out daily to either sit in the park, visit 'mates' or do a bit of shopping.

5.6.10. Michael told professionals that he was unable to see his children during the covid lockdown but in contrast, Sandra has said that Michael was in a 'bubble' with his ex-partner and children and therefore was able to maintain some regular contact. It is very unlikely that this review will ever learn the definite movements of Michael during the covid lockdown and/or understand how it affected Michael's daily routines, but for people like Michael experiencing dual diagnosis, an already complex set of circumstances which is likely to be influenced by their emotional responses to external stresses, the covid pandemic was a difficult time.

5.6.11. It is known that people with mental health conditions are highly susceptible to stress and that a person could then subsequently attempt to self medicate by means of drugs and/or alcohol – risking further deterioration of their mental health.

5.6.12. According to the World Drug Report 2021[23] by the United Nations Office on Drugs and Crime, around 275 million people used drugs worldwide in 2020, a figure that was up by 22% from 2010.

5.6.13. The covid lockdown saw an overall increase in alcohol consumption during covid 19. In July 2021 Public Health England released a paper called 'Alcohol consumption and harm during the covid 19 pandemic'[24]. The findings show an increase in the heightened risk level of alcohol consumption from 2020 to 2021. However, post 2021 the levels have returned to normal - suggesting that it was lockdown which saw this rise in alcohol consumption. From March 2020 to March 2021, there was an increase of 59% in people who reported to drink over 50 units a week for a man, and over 35 units per seek for a woman.

5.6.14. The increase in alcohol consumption during covid 19 saw a rise in alcohol-related deaths. Fatalities relating to alcohol rose by 20% in 2020, going from 5819 in 2019 to 6983 in 2020.

5.6.15. Deaths from a rise in behavioural and mental disorders, due to alcohol, rose from 2019 to 2020 at 10.8%

5.6.16. This review has questioned whether Michael was at higher risk of suicide during the covid restrictions given his suicidal ideations. But whilst it is known that more people sought mental health support during the covid pandemic, the University of Manchester scientists[25] found a broadly similar suicide rate from April to October 2020 to that seen between January and March. Using real-time surveillance data (which records suicides as they occur but before an inquest is held) academics studied suicides in areas of England covering around a quarter of the population. They found that the suicide rate between January and March 2020 was 125.7 per month compared to 121.3 per month between April and October. Comparing 2020 to 2019, the data showed a total of 633 suicides between April and October 2019, compared to 637 during the same months in 2020.

5.6.17. In summary, whilst the personal effects of the pandemic on Michael remain unknown, restrictions imposed on professionals' working practice (which resulted in less face-to-face contact and an inability to meet with any person who reported covid symptoms), caused Michael, an already hard to reach individual, to be harder to reach.

6. Good Practice

There is evidence of much good practice within several agencies who attempted to support Michael and it is equally important to develop learning from this good practice as it is from any shortcomings:

6.1. Professional attendance and engagement at the learning event was excellent.

6.2. The liaison teams shared information and concerns with other services frequently.

6.3. There is evidence of proactive outreach when Michael did not attend a scheduled telephone appointment with Achieve.

[23] World Drug Report 2021 (unodc.org)
[24] Alcohol consumption and harm during the COVID-19 pandemic - GOV.UK (www.gov.uk)
[25] Suicide in England in the COVID-19 pandemic: Early observational data from real time surveillance - The Lancet Regional Health – Europe

6.4. Achieve clinicians updated the referrer (Rapid Response Team) of missed appointments.

6.5. Police Officers made referrals to external services when they did not have Michael's consent but believed the need to share the information overrode his decision to not consent. This ensured appropriate safeguarding was addressed by supportive services and is in line with the Adults at Risk Policy 2020.

6.6. The GP was creative with the methods utilised to ensure face-to-face contact with Michael, for example, she held back repeat prescriptions so that Michael would contact the surgery.

7. Improving Systems and Practice

7.1. Developments since the Scoping Period of this Review

Since the scoping period of this review, agencies have already made some important amendments to practice. Some have been included in the body of this report. Other developments include:

7.1.1. The Six Town Housing Neighbourhood Team is realigning, and their Tenancy Support offer has been increased in recognition of the increasing complexities/tenancy supporting needs of tenants. The Tenancy Support Teams are now patch based and split around the North and South areas of the Borough. There are 12 Tenancy Support Advisors, 1 Independent Living Advisor and 1 Independent Living Manager within the structure. The link with other services, including a 'Support at Home' offer for customers who would benefit from this service is key and a 'Support at Home' leaflet has been shared with the Team to raise awareness of the range of support that can be put in place. Initial patch splits/demand in areas of the borough and Tenancy Support referral criteria are currently being reviewed. To better understand the needs of customers - the main reasons for referral to Tenancy Support are also being reviewed. It is clear that mental health issues are a common thread in many Tenancy Support referrals along with property condition/substance addictions/finances and engagement difficulties. Training for specific priority areas for Tenancy Support team are being sourced.

7.1.2. The Greater Manchester Mental Health NHS Foundation Trust Level 3 Safeguarding Adults Module has recently been strengthened in areas around self-neglect and mental capacity, which includes executive capacity.

7.1.3. The Greater Manchester Mental Health NHS Foundation Trust is leading on the design and delivery of a *Greater Manchester Learning from Reviews Module*, which covers:

1. Key section of the Care Act i.e., sections: 9, 10, 11, 23, 27, 42, 44, 67 and 76
2. Mental capacity and executive capacity
3. Challenges in dealing with fluctuating capacity
4. Service refusal
5. Advocacy
6. Harmful effects of labels i.e., replacing the term 'challenging behaviour' with 'distressed behaviour' to encourage practitioners to explore why the person is behaving as he/she is. We need to focus on the cause of the distress and take the time to explore why the person is behaving in that way and recognise signs which could assist in preventing the behaviour escalating.
7. Different approaches i.e., Rights-Based and Strengths-Based Approaches
8. Trauma Informed Care
9. Multi-Agency Meetings i.e., Multi-Agency Team Around the Adult

7.1.4. The NHS Foundation Trust is also currently in the process of reviewing and strengthening the Safeguarding Adults at Risk Policy and Safeguarding Adults at Risk Procedure and Practice Guidance in the same areas listed. These policies are in consultation phase for review and will be formally published after ratification.

7.1.5. The Access and Crisis Team are forming pathways with the Primary Care Network Mental Health professionals and joint home visits will be considered going forward.

7.1.6. Bury liaison is going to become a core 24 service in 2022, this will mean that anyone presenting to a general hospital A&E department or medical ward with symptoms of poor mental health can be referred for an assessment of their mental health.

7.1.7. February 2021 has seen Greater Manchester Police introduce the THRIVE[26] risk assessment framework into practice. This is aimed at supporting Operational Communications Branch staff to better identify vulnerability, threat, harm, and risk within open incidents and is in support of Greater Manchester Police Force's Think Victim campaign. The introduction to the THRIVE to officers' states, "The THRIVE risk assessment framework will align Greater Manchester Police with other forces across the country and will drive action that will give our victims the support they deserve and safeguard the most vulnerable in our communities".

7.1.8. In November 2021 Adult Social Care undertook an external review of Adult Safeguarding pathways and process. A robust action plan was developed and is due to be implemented in October 2022 when the new Head of Adult Safeguarding comes into post.

7.1.9. In October 2021 BISP introduced a Multi Agency Risk Management protocol. All complex high-risk cases where the adult:

- Has the mental capacity to understand the risks posed to them
- Continues to place themselves at risk of serious harm or death
- Refuses or is unable to engage with health and social care services

are now referred through this protocol which is chaired and attended by partners at senior management level.

7.2. Conclusion

7.2.1. The workings of this review have highlighted the complexity of Michael's life. As a person living with dual diagnosis Michael found himself unable to maintain relationships, manage a career, and consistently meet his own care needs independently. Michael was also unable to recognise potential exploitation from associates who he considered to be his 'friends' and who also experienced substance misuse, and/or problems with their mental health.

7.2.2. Services were unable to engage Michael consistently. Indicative of the fact that a professional approach to such non-engagement needs to urgently be identified is that poor engagement is a recurring feature in Safeguarding Adult Reviews across the country.

7.2.3. Initially, to address Michael's non-engagement, priority needed to be given to developing an understanding of Michael's life experiences. To do this, professionals working around Michael needed to test multiple ways of engaging with him and to promote a rehabilitative framework in which Michael was able to recognise the potential to facilitate a recovery and bring an improved quality to his life.

7.2.4. Whilst this report recognises that any person who has capacity and whose mental health does not warrant detention under the Mental Health Act 1983 has the right to refuse treatment/services, in the absence of achieving good enough engagement, professionals needed to give serious consideration as to:

- Michael's executive functioning, and
- whether Michael presented as being a risk to himself (including self neglect and exploitation) or a risk to others.

Safeguarding/professionals meetings needed to convene to discuss this and any required escalation.

[26] Threat, Harm, Risk, Investigation, Vulnerability, Engagement.

7.2.5. Instead, professionals relied upon the Integrated Neighbourhood Teams Active Case Management. This was inappropriate as Active Case Management is a forum which met every four weeks to monitor and review Michael. Michael would never have been discussed in these meetings on an urgent basis, even if in crisis.

7.2.6. Despite it being important that all professionals working to support Michael had an awareness of the other people in Michael's life, there is little evidence of professionals applying a Whole Family approach to Michael's circumstances. This was partly owing to Michael not easily divulging information but in the absence of meaningful engagement professionals needed to practice respectful uncertainty and take a thorough approach to guard against any false information he imparted. Particularly as it was crucial that any impact/risk of Michael's behaviours upon his children be assessed.

7.2.7. An element of professional contact with Michael's mother may have helped professionals to understand Michael, monitor any deterioration of Michael's circumstances and better assess Michael's risk and vulnerabilities to exploitation.

7.2.8. Nevertheless, professionals worked hard to support Michael, particularly during difficult times which were punctuated with changing policies and restrictions to service, owing to the covid pandemic. But regrettably Michael's substance misuse and mental health problems continued to deteriorate.

7.2.9. In the absence of services being able to engage Michael with support he followed a path of self-neglect which sadly eventually led to his death.

7.3. Questions for the BISP

The review would ask BISP to deliberate the following questions. It is the responsibility of BISP to use the ensuing debate to model an action plan to support improvements to systems and practice.

- Question 1 for BISP: How can Senior managers in Adult Social Care reassure BISP that future referrals to Bury Connect and Direct Hub will be screened at the correct level?

- Question 2 for BISP: How can the Integrated Neighbourhood Team assure BISP that new staff, including managers, will be trained, and supervised effectively to prevent future referrals being closed inappropriately?

- Question 3 for BISP: How can Greater Manchester Police, North West Ambulance Services and Adult Social Care work to improve the referral system, and evidence improved efficiency to BISP?

- Question 4 for BISP: How can partner agencies assure BISP that their professionals understand changes to the Mental Capacity Act Code of Practice and learn how to apply the act to people whose capacity may fluctuate? For example, those with substance misuse problems.

- Question 5 for BISP: How can BISP explore and address whether professionals from all agencies:
    - Are becoming over reliant upon the Integrated Neighbourhood Team when they know that a case is under Active Case Management,
    - Understand that the Active Case Management pathway is not a substitute for Safeguarding Pathways and that the two can run parallel?

- Question 6 for BISP: How can BISP be reassured that professionals from all agencies are aware of executive functioning and able to confidently consider a person's executive capacity within capacity assessment?

- Question 7 for BISP: How can BISP work with partner agencies to change the use of labels (for example 'does not engage') that are in danger of apportioning blame and contrast with a person-centred, strengths-based approach.

- Question 8 for BISP: How can BISP develop practice with all partner agencies which will:

- make services more inclusive for hard-to-reach people,
- learn from examples of best practice, and
- ensure that decisions to close a case in all agencies due to not being able to engage with a service user, are subject to robust supervision discussion?

- Question 9 for BISP: How can agencies and organisations assure BISP that professionals are being reminded to take a holistic 'Whole Family' approach when considering an Adult at Risk, and how can Children's Social Care and Adult's Social Care assure BISP of a 'Whole Family' approach which encompasses efficient information sharing and affords both agencies best visibility of a service users' circumstances.

- Question 10 for BISP: How can BISP promote/explore whether members of the public understand 'what safeguarding is' and ensure that members of the public know who to contact with concerns about any Adult at Risk?

8. Appendix 1

Terms of Reference

- Identify the safeguarding concerns for Michael, explore assessment of his care and support needs under the Care Act, and examine the progression of safeguarding referrals.
- Explore the function of the Integrated Neighbourhood Team and how Michael's risk was managed by agencies.
- How did agencies work together to support Michael with his decision-making?
  - Around his engagement with professionals and services
  - Under the provisions of the Mental Capacity Act
- Was Professional Curiosity influenced by Unconscious Bias?
- How did agencies work to support Michael with?
  - Dual diagnosis
  - Self-neglect
- Did professionals employ a 'Whole Family' approach to consider the impact of any of Michael's struggles on other family members and to obtain an overview of family risks, relationships, needs and strengths.
- Did professionals consider and/or recognise any potential abuse or exploitation of Michael?
- To what extent, if any, did the covid pandemic affect the service and support offered to Michael?