SAFEGUARDING ADULTS REVIEW: CHRIS

Abridged Executive Summary
based on original Report by Pete Morgan BA, MA, & CQSW

Please note that this document has been anonymised by the use of pseudonyms to protect the identity of those concerned

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1. Introduction

Chris was a 47 year old gentleman who had an established diagnosis of Paranoid Schizophrenia and a history of drug and alcohol use.

Chris suffered from osteoporosis and back pain. He was also diagnosed with Barrett's Oesophagus. He had four fractured vertebrae, two of which had collapsed – his physical presentation included curvature of the spine. More recently, concerns were noted in relations to liver damage as a result of chronic and increased alcohol use.

Chris had received support from a care coordinator over the years and regular reviews by the Consultant Psychiatrist. More recently his care coordinator was a Community Psychiatric Nurse (CPN) and he was supported under the Care Programme Approach (CPA.) He had also resided in supported and semi supported accommodation in the past, received support packages including daily care visits and cleaning support.

Chris was detained to the Cavell Centre under section 2 of the Mental Health Act, prior to being admitted to A&E complaining of chest pain. Whilst at Hospital, his physical health continued to decline and he died on the 4th March 2023

Chris's death was referred to the Coroner, who recorded the cause of death as "1a Liver Failure 1b Wilson's Disease and Alcoholic Liver Disease and 2 Pneumonia." The Coroner's office submitted a referral for a SAR on the 27th July 2023.

The original SAR report was lengthy and detailed and therefore an abridged version in this executive format has been produced with author's consent

2. Terms of Reference and Key Lines of Enquiry

The scope of the SAR was set as the period from the 1st January 2022 until the 4th March 2023

Agencies were asked to include a summary of any earlier information about their involvement with Chris if they considered it to be of particular relevance to the Review. Specific areas to focus on and key areas to be analysed included:

- Mental Capacity Act 2005
- Care Programme Approach (Community Mental Health Framework)
- Care Act 2014 assessments and reviews
- Transfer of safeguarding information - Was there effective information sharing between agencies - If not, how could this have been improved
- Management overview of risk management
- Staff supervision
- Were there any areas of good practice in this case

3. Methodology

Information trawls were completed on Chris to identify which agencies had had relevant contact with him during the period of the Review.

Chronologies were requested from the following agencies with regard to their involvement with Chris and his family:

- Bretton Medical Centre

- Cambridgeshire Constabulary
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cross Keys Homes
- East of England Ambulance Service
- Herts Urgent Care
- Longhurst Group
- North West Anglia Hospitals Foundation Trust
- Peterborough City Council Adults Social Care

Peterborough City Council (PCC) delegates its statutory Mental Health Social Work to Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) via a Section 75 and therefore for clarity within the report, when the author refers to social work or social worker this is CPFT delivering the delegated statutory functions on behalf of the Council.

4. Family Involvement

The Independent Reviewer met with Chris' father who provided some additional background information about Chris which has been incorporated into this report.

Chris only had contact with his birth family once; before he was adopted, he was taken to meet his brothers but became upset when he thought he was being left with them. Chris' father understood that his birth mother had mental health issues but is not aware whether Chris knew this or not. He did appear to "have a chip on his shoulder" about being adopted.

Chris' father stated that, before her death in 2015, his late wife would attend any reviews or meetings about Chris, but that they were never formally invited to them but were dependant on Chris telling them about them. He had found attending any such meetings distressing as Chris would only participate if they went the way he wanted them to and would become verbally aggressive and unpleasant – something which was typical of Chris' behaviour. While his father thought Chris accepted that he needed support, he would only accept it on his own terms.

Chris' father could not remember ever being advised of his rights as Chris' Nearest Relative under the Mental Health Act or being involved in any assessment of Chris' health or social care needs and therefore felt unable to comment upon the services offered or received by him.

Chris had left school without any qualifications and worked spasmodically as a general labourer but had always had difficulty managing his money, resulting in his trying to borrow money from his parents and, ultimately, resorting to burglary, for which he served a prison sentence.

Chris didn't have a close relationship with his family and hadn't ever visited his parents at the address where his mother died and his father still lives.

The Independent Reviewer advised Chris' father that he would be given the opportunity to see and comment upon the findings and recommendations contained in the final draft of the Report before it was presented to the Board.

5. Background

Chris was a 47 year old man and living on his own in a rented bedsit, managed by Cross Keys Homes, at the time of his final admission to hospital and death. He had held the tenancy since May 2019. Cross Keys Homes are a commercial business that provides affordable housing for rent or for sale as "shared ownership" and a range of support services.

Chris was well-known to local mental health services, having first been referred to them at the age of 19, presenting with psychotic symptoms. He received a sentence of 3.5 years in a Youth Offenders Institution in 1995 for two offences of theft apparently committed to fund a drug habit but was transferred under s37 of the Mental Health Act 1983 to the Norvic Clinic in Norwich, run by the Norfolk and Suffolk NHS Foundation Trust, where he was diagnosed with Paranoid Schizophrenia where he stayed until 1998.

In January 2000, he was evicted from a hostel in Peterborough and admitted to the Lucille van Geest Ward, a mental health ward run by Cambridgeshire and Peterborough Foundation Trust until August 2000 as his mental health had deteriorated. He was readmitted to hospital informally several times before 2015, from which time he was supported in the community by local mental health services.

Chris had a history of drug and alcohol misuse and was supported by ASPIRE, though he did not always engage with the service. He also had a history of physical health issues: he suffered from back pain and osteoporosis and had been diagnosed with Barrett's Oesophagus, a condition that affects the tissue in the oesophagus which links the throat and the stomach; he had four fractured vertebrae (cause not known) two of which had collapsed, leaving him with a stooped presentation and there were concerns of possible liver damage as a result of chronic and increased alcohol consumption. It was being investigated whether he had Wilsons' Disease, a genetic disorder causing excessive copper accumulation in the liver, brain and other organs, when he died.

Due to his chronic mental health issues, Chris's support in the community was coordinated under the Care Programme Approach and was regularly reviewed by a Consultant Psychiatrist.

At the time of his final admission to hospital, Chris was receiving a support package of three visits a day and a weekly shopping call and a four hour cleaning call a week. A s42 Safeguarding Enquiry was initiated after a safeguarding concern had been raised by his allocated Social Worker into alleged neglect or acts of omission by Chris's GP Practice.

On the 7th February 2023, Chris was assessed and admitted to The Cavell Centre under s2 of the Mental Health Act 1983 due to concerns about his physical health, he was transferred to the Peterborough City Hospital (PCH) on the 9th February 2023 where a Deprivation of Liberty Safeguard (DoLS) was applied for to prevent him leaving the ward. He was discharged from the s2 admission on the 23rd February 2023 as his mental health needs were no longer the primary concern and the DoLS was renewed. His physical health continued to decline and he died on the 4th March 2023

Chris's death was referred to the Coroner, who recorded the cause of death as "1a Liver Failure 1b Wilson's Disease and Alcoholic Liver Disease and 2 Pneumonia." The Coroner's office submitted a referral for a SAR on the 27th July 2023.

6. Significant Incidents and Review Findings

Mental Health Act 2009

Chris had been known to mental health services for over 20 years having been transferred under s37 of the Mental Health Act 1983 from prison to the Norvic Clinic in Norwich; the Review is aware his mental health and care and support needs were meant to be managed under the Care Programme Approach. This, combined with his entitlement to support services under s117 of the MHA, should have led to regular reviews of his mental health and the consideration of the need for a formal assessment under the MHA.

At no stage until July 2022 was Chris referred for such a formal assessment and seen by an Advanced Mental Health Practitioner; even then, the decision was not to complete the assessment as Chris was deemed to have capacity to request an informal admission to the Cavell Centre, despite no formal capacity assessment being recorded.

Chris was next seen by an AMHP in February 2023, resulting in his compulsory admission under s2 of the MHA within a matter of days. While there is an argument of using the least restrictive option to justify not admitting Chris under s3 of the MHA, it is debateable given the long-standing nature of his mental health, the existing diagnosis and the unsuccessful treatment plan, whether this would have been more appropriate.

Throughout the Review Period there were repeated instances of Chris' mental health deteriorating without any remedial action being taken to address it. Referrals were made to the Crisis Team, but these were always unsuccessful and his care returned to the PALT.

Throughout the Review Period, there is clear evidence of Chris' self-neglect terms of his physical appearance, his physical health and the state of his flat; there is no evidence that was considered in the light of and linked to his mental health issues. Chris had specific physical health conditions that may have impacted on his mental health, either directly or indirectly by effecting his ability to take his medication.

There were a number of multi-agency procedures that should or could have been initiated to coordinate the assessment of Chris' mental health and social care needs, to identify and plan how they could be met and monitor the outcomes of any support packages. Key to this was the powers and duties inherent in the MHA and the CPA.

What does appear to be the case is that Chris' behaviour, his self-neglect, failure to comply with medical advice, his aggressive verbal and physical behaviour, and hallucinations, was normalised as being part of Chris rather than indicative of his mental health issues.

The Care Act 2014

Having been compulsorily admitted to hospital under s3 of the Mental Health Act 2009, thereby being eligible for s117 after care, Chris should have been offered an assessment or review of his social care needs under the legislation that applied at the time both when he was discharged from hospital and at any subsequent review under s117.

As Chris's health and social care needs were being managed under the CPA, he should have been offered an assessment or review of his social care needs on his discharge from hospital and at any subsequent review under the CPA. He was assessed under s9 of the Care Act in August 2015 but there was no review of his social care needs until October 2019.

Mental Capacity

At no stage during this period is there any reference to Chris having capacity or to any consideration of whether he did or didn't despite his repeated making of what could be seen as Unwise Decisions about his physical health and general self-care.

While there is a clear requirement under the Mental Capacity Act 2005 (MCA) to assume that an individual has capacity until they are shown to not have it, there is also a duty in the Code of Practice that supports the MCA to consider an individual's capacity if they make continued Unwise Decisions, if they demonstrate a possible inability to learn from experience.

Chris' continuing to make Unwise Decisions should have led to a consideration if not a formal assessment of his capacity to make decisions about his health and social care needs. This is not to suggest that he did lack that capacity,

Until Chris was admitted to hospital in February 2023, there had been no formal assessment of his capacity, despite his repeated making of what could only be considered Unwise Decisions about his physical and mental health, resulting in his self-neglect.

While the MCA makes it clear that adults are fully entitled to make Unwise Decisions and an assessment of their capacity should not be based on their appearance or eccentric behaviour, the Code of Practice that supports the Act also makes it clear that repeated Unwise Decisions and an apparent inability to learn from experience should lead to a consideration of whether the individual has capacity to make the particular relevant decisions.

There were numerous occasions during the Review period where the opportunity to consider Chris' capacity to make decisions about his physical and mental health and his self-neglect arose without being taken. These include times when Chris was considered to have capacity and services were withdrawn despite his refusing treatment and obviously hallucinating.

There was also an occasion where an assessment under the MHA was not completed on the basis of Chris having the capacity to request an informal admission to hospital – he was making such a request at the time – without a formal assessment of his capacity. In other words, his request for admission was rejected without either his capacity or his mental health being formally assessed.

When Chris' capacity was considered and assessed when he was admitted to hospital in February 2023 and a DoLS applied for, this was only after he had been in hospital for seven days.

It would again appear that Chris' behaviour, his self-neglect, failure to comply with medical advice, his aggressive verbal and physical behaviour, and hallucinations, was normalised as being part of Chris rather than indictive of a potential lack of capacity

Self-Neglect and Safeguarding

When Chris was assessed under s9 of the Care Act 2014 in August 2015, issues of neglect of his home environment and poor self-care were noted; when a safeguarding concern was raised in April 2017, this was not linked to the previous concerns of self-neglect and the concern did not progress to a s42 Enquiry

In June 2020, concerns were raised about the state of Chris' home, photos were taken and the property was described as being in an unhygienic state – flies, rotting food and human faeces on the floor; – but no safeguarding concern was raised.

Prior to the Review Period, there was a lack of recognition regarding Chris' self-neglect as a form of abuse or to raise safeguarding concerns on the basis of it. This continued through the Review Period and was compounded by not including the issue of his self-neglect when safeguarding concerns were raised about Chris.

Chris' self-neglect was identified at various times during the Review Period but didn't lead to a safeguarding concern being raised; this despite Chris meeting the criteria contained in the Care Act, namely having identified care and support needs and experiencing abuse.

On one occasion, the Police did raise a safeguarding concern that was passed to the Police MASH. Unfortunately this wasn't forwarded to Adult Social Care as the Police were told that as

Adult Social Care were already involved with Chris no referral was required. This review has prompted a discussion in relation to this point and it was agreed that the Safeguarding Adults Boards would consider it to be good practice to forward any safeguarding concerns to Adult Social Care. Given that even if Adult Social Care are involved with the adult, this may be new information that Adult Social Care are not aware of.

Similarly, a safeguarding concern that was raised about possible theft by Chris' cleaners was not progressed on the basis of it being a possible crime that required investigation by the Police. This presupposes an absolute distinction between crime and abuse, while the reality is that abuse can also be a crime and may require a response under both the Safeguarding Procedures and the Criminal Justice System. The alleged perpetrators also posed a potential risk to other adults with care and support needs they supported.

When a safeguarding concern was raised about Chris in February 2023, it was after he had been in hospital for nearly 2 weeks but related to the period prior to his admission. This resulting s42 Enquiry was then led by one of the professionals who raised the initiating safeguarding concern and was not converted to a SAR when Chris died – a s42 Enquiry can only relate to a living subject. The referral for the SAR was made by the Coroner in July 2023, some 5 months after Chris died.

Multi-Agency Risk Management

In November 2020, Chris was referred into the Multi-Agency Risk Management process due to concerns about his physical health and self-neglect. An action plan and safety net was agreed. The MARM continued to be reviewed in December 2020, February 2021 and May 2021 but it was never subsequently reconvened. Equally, there is no evidence of the implementation of the Action Plan agreed under the MARM process being monitored or reviewed when it was not being successful.

There were numerous occasions during the review period where Chris continued to self-neglect and was deemed to have capacity but kept refusing to engage with services regarding his pressure sores, non-compliance with his medication and not attending his GP appointments for physical health checks. There does not appear to have been any consideration to refer back in to the MARM process.

Multi-Agency Working

Chris was often in contact with the Ambulance Trust, both on the phone and face-to-face, but details of these contacts don't appear to have been shared either with his GP Practice or with Adult Social Care. Between February and May 2022, the Ambulance Trust record 10 contacts with Chris.

There are examples of Chris attending PCH, including times when he was prescribed medication, when his GP Practice was not advised of the attendances or their outcomes.

There are also examples of a lack of information sharing between social care agencies about contacts with Chris and their outcomes.

While the above relate to information sharing about individual contacts with Chris, there is wider issue about the use of multi-agency procedures to coordinate the assessment of Chris' physical and mental health needs as well as his social care and support needs.

Despite Chris having a known problem with alcohol misuse, there is limited evidence of consideration being given to referring to him to the appropriate support service or his being advised/supported to agree to a referral.

Chris had a complex combination of physical and mental health issues as well as the need for social care and support that required coordinated input from a range of agencies; there were multi-agency procedures that should and could have been initiated to ensure a holistic approach to supporting him in the community, drawing on the expertise of a range of agencies and professionals to ensure services weren't working in isolation and potentially at cross purposes.

It has been suggested that insufficient consideration was given to the impact of his physical health issues on his general situation; had the above multi-agency procedures been initiated, this might have been avoided.

The review indicated that there were gaps in documenting contacts in the GP records including the receipt of hospital records. The GP practice reviewed this with the author and provided assurance that hospital letters were received. In addition a high number of contacts where Chris did not attend booked appointments were known. The GP practice continue to review prompt uploading of letters received from other agencies onto their patient record system. The GP practice have a flagging system for non-attendances and will continue to review frequent non-attendance with practice staff for appropriate action. The review indicated potential delay in medication prescription however the GP practice informed the author that the medication change and new prescription was provided by CPFT in correspondence with the GP practice and Chris received his medication within expected timeframes.

The Findings relating to the Ambulance Trust all, apart from one, relate to the Trust not advising other agencies, particularly his GP know of their contacts with Chris and their outcomes, despite their frequency.

The other Finding related to the Trust not considering or raising a safeguarding concern after ten contacts in a 3 month period, including one when it was recorded "Psychiatric suicide, patient on the floor – voices in head".

While it must be acknowledged that it isn't standard practice to routinely inform GPs or Adult Social Care of all ambulance attendances, due, at least in part to the time this would lead ambulance crews to be "off the road" to complete the referrals and the crews not being aware of the patient's history or previous attendances, this doesn't apply to call handlers, who could also forward electronically details of the attendance and its outcome.

Any issue of the patient's consent being required before information could be shared doesn't prevent hospitals sharing information about hospital attendances and doesn't apply to the raising of safeguarding concerns.

The majority of the Findings relating to PCH refer to Chris' GP Practice not being informed of attendances at the hospital and the prescription of medication.

One Finding relates to an attendance when Chris left without being seen and no referral-on being made.

There are several instances of Adult Social Care and the Longhurst Group's records not showing some contacts with Chris or failing to record their outcomes.

There are several instances of Adult Social care's record not detailing which professional carried out a particular action, just their profession.

The issue of Adult Social Care's recording is complicated by the use of two computer-based recording systems – Mosaic and SystemOne - and the at times different or contradictory information recorded on each.

There was one occasion where the Police did not raise a safeguarding concern after Chris alleged that he had been raped by his neighbour and that he was hearing voices. This incident resulted in Chris assaulting the neighbour. The Police later raised a safeguarding concern internally to the Police MASH but didn't forward it to Adult Social Care who they knew were supporting Chris.

The Police recorded a crime of assault against Chris on the neighbour and after investigation the situation was resolved out of court with Chris attending an anger management course rather than going through mental health or safeguarding processes.

When Chris later admitted that he hadn't been raped and that the voices in his head had told him to make the allegation, this was a further missed opportunity to explore Chris' mental health. This was specifically in relation to the voices that Chris said he was hearing, and the impact of this on his behaviour.

Non-compliance with medical advice

Chris often refused to follow medical advice or attend appointments, which was influenced by his mental health issues, including paranoia and hallucinations. For example, he frequently missed appointments for treating his pressure ulcers and other physical health issues, believing that he didn't need the treatment or that the medical staff were trying to harm him. There were a number of occasions where he said he was too busy to attend appointments as he was going shopping.

Normalisation of Behaviour

Chris's behaviour, influenced by his mental health, was often normalized by healthcare providers. His self-neglect, aggressive behaviour, and refusal to comply with medical advice were sometimes seen as just part of his personality rather than symptoms of his mental health issues that needed to be addressed.

Good Practice

Staff involved with Chris, particularly those providing direct support to him, demonstrated a high level of commitment to supporting him in the community. There were examples of good practice relating to information sharing, prompting Chris to attend appointments, encouraging him to make better decisions about his physical and mental health and seeking to involve him in the decision making about his life and situation. What appears to have been lacking was management oversight and monitoring of the procedures and systems designed to ensure that assessments, support packages and outcomes were effective and appropriate.

7. Conclusions and Recommendations

Chris had been known to mental health services, both health and social care, since 1998; he was eligible for aftercare under s117 of the Mental Health Act 1983, his social care and support needs had been assessed under s9 of the Care Act 2014 in August 2015 and his health and social care needs were meant to be managed under the Care Programme Approach.

This Review saw no evidence of any formal reviews of Chris support packages under the CPA or the Care Act and no effective reviews under s117. As a result, his care and support needs with regard to his mental and physical health and his social care were not appropriately assessed or met.

This Review saw no evidence of any monitoring procedures being in place to ensure that reviews were routinely held under the above multi-agency procedures.

Recommendation 1: That the Board seek assurance from the statutory agencies that robust procedures for assessing and reviewing support packages in the community are in place and monitored.

Despite there being cause for concern throughout the Review Period, there was no formal assessment under the MHA of Chris' mental health until February 2023; he was seen by an AMHP in July 2022, but no formal assessment was completed on the basis that he had the capacity to request an informal admission to hospital. No formal assessment of his capacity was made at the time when he was requesting that he be admitted to hospital.

Recommendation 2: That the Board seek assurance that assessments under the MHA are initiated as and when appropriate

Recommendation 3: That the Board seek assurance that statutory agencies have in place appropriate staff development opportunities to ensure the awareness of the distinctions between MHA and MCA assessments

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Common to several Themes identified in the Analysis was a concern about the apparent acceptance and normalisation of Chris' behaviour by staff across agencies. While this is an understandable response by staff working with behaviour that is, almost by definition, atypical for the majority of the population, it should be resisted and guarded against through professional supervision and multi-agency procedures that encourage professional curiosity and reflective practice.

Recommendation 4: That the Board seek assurance from all partners that staff have access to professional supervision and multi-agency forums that encourage professional curiosity and reflective practice.

Specific to Adult Social Care was the Finding that their duties to offer and review assessments of Chris' care and support needs under s9 of the Care Act 2014 was not met. Although not identified in the Analysis, the same can be said of their duty to offer assessments under s10 of the Care Act to Chris' family.

Recommendation 5: That the Board seek assurance from Adult Social Care that they have robust procedures and monitoring processes in place for assessments under the Care Act 2014

Throughout and prior to the Review Period, there were numerous examples of Chris' self-neglect being identified but without a safeguarding concern being raised or being considered alongside other possible forms of abuse. At one stage, Chris was referred to the MARM as a result of his self-neglect, despite being in receipt of support under the Care Act 2014.

Recommendation 6: That the Board seek assurance that self-neglect is clearly identified within safeguarding procedures as a form of abuse under the Care Act.

On one occasion, the Police MASH correctly assessed as a safeguarding concern raised by the Police didn't meet the criteria for progressing to a s42 Enquiry but did not forward the concern to Adult Social care for their information; on a second occasion, the ASC MASH didn't progress safeguarding concern on the grounds that it was a possible crime that should be investigated by the Police, not recognising that it could be managed under both the Safeguarding Procedures and the Criminal Justice System.

Recommendation 7: That the Board seek assurance that the Police MASH has robust procedures in place to ensure that safeguarding concerns are correctly triaged and acted upon.

A safeguarding concern wasn't raised about Chris until nearly 2 weeks after his admission to hospital; when it was correctly triaged as needing to progress to a s42 Enquiry, it was allocated to one of the professionals who raised the initiating safeguarding concern and when Chris died before the s42 Enquiry could be completed, it wasn't referred for a SAR despite a S42 Enquiry only being appropriate when the subject is alive. The referral for a SAR wasn't made until some four months later by the Coroner.

Recommendation 8: That the Board seek assurance to ensure safeguarding concerns are raised in a timely manner and s42 Enquiries are managed in accordance with the Care Act and its supporting Statutory Guidance.

While there is no evidence to demonstrate that Chris lacked capacity in any areas of decision-making, there is clear evidence if his making repeated Unwise Decisions about his physical and mental health and self-care, as exemplified by his self-neglect. The MCA requires an assumption of capacity until the opposite is evidenced but the Code of Practice that supports the Act recognises that repeated Unwise Decisions should lead to a consideration of the individual's capacity.

Recommendation 9: That the Board should seek assurance from all partners that staff are aware of the need to consider the individual's capacity in cases where there are repeated Unwise Decisions, particularly where self-neglect is an issue, and that the outcome is clearly recorded.

When Chris was admitted to hospital in February 2023, despite his being identified as lacking the capacity re medical treatment, there was a delay of seven days before a formal capacity assessment was completed and a DoLS applied.

Recommendation 10: That the Board seek assurance from North West Anglia Hospitals NHS Foundation Trust that they have reviewed and revised their MCA procedures.

Chris' care and support should have been managed under several multi-agency procedures – s117 MHA, MARM, CPA, Safeguarding and s9 Care Act 2014 – but these weren't implemented effectively or coordinated to ensure a holistic approach to his physical and mental health and care and support needs. This was compounded by both an apparent acceptance and normalisation of Chris' behaviour by staff across agencies and not working with him to address his alcohol misuse or the possible impact of his physical health issues on his mental health, as can be seen from the below.

Recommendation 11: That the Board seek assurance from partner agencies that they have reviewed and revised as necessary the relevant multi-agency procedures and their monitoring processes.

Linked to the above was the lack of routine information sharing by the Ambulance Trust and PCH with Chris' GP Practice about their contact with him; this is also true to a lesser extent to the Ambulance Trust and Adult Social Care

Recommendation 12: That the Board seek assurance that the Ambulance Trust and the Emergency Department at PCH have reviewed and revised as necessary their recording procedures and the processes for informing GP Practices and Adult Social Care of any contact with patients.

There was also a lack of routine information sharing between the social care agencies who were supporting Chris.

Recommendation 13: That the Board seek assurance from Adult Social Care that it has reviewed and revised as necessary its procedures for information sharing to support multiagency care packages.

The Review identified gaps and inaccuracies in the records of the BMC of their contacts with Chris which led to the complexity of his health and social care support needs and his support network not being reflected or recognised.

Recommendation 14: That the Board seek assurance from the ICB that they have reviewed and revised as necessary the recording standards required of GP Practices.

The above also applied to Adult Social care's records, but this was exacerbated but the complications caused by the use of two computer-based recording systems by social workers and health care professionals.

Recommendation 15: That the Board seek assurance from Adult Social Care and Mental Health Services that they have reviewed and revised as necessary their joint recording systems.

The Police had limited contact with Chris; they did raise one safeguarding concern with the Police MASH correctly, but on two occasions did not do so. One was reviewed internally and deemed not to meet the criteria to forward to the MASH but it wasn't forwarded to Adult Social care despite knowing they were supporting Chris and on one occasion they didn't raise a safeguarding concern internally.

Recommendation 16: That the Board seek assurance from the Police that they have reviewed and revised as necessary their thresholds and procedures for raising, triaging and forwarding safeguarding concerns appropriately

As has been noted earlier, just over a third of the Review's Findings identified Good Practice. Staff involved with Chris, particularly those providing direct support to him, demonstrated a high level of commitment to supporting him in the community.

Recommendation 17: That the Board seek assurance from partner agencies that they have acknowledged with the relevant staff and their managers the examples of Good Practice identified in the Review.

However, what appears to have been lacking was management oversight and monitoring of the procedures and systems designed to ensure that assessments, support packages and outcomes were effective and appropriate. Even if this had happened, as Chris had a history of not cooperating with the services and agencies that had a duty and indeed attempted to support him in the community, it is likely that he would still not have cooperated and put himself at risk through self-neglect. What is not and never will be clear is whether earlier diagnosis and treatment of his Wilson's Disease would have led to his being more cooperative and therefore enhanced his quality if not extended the duration of his life.

Appendix 1 - Agency Involvement prior to review period

In February 2015, Chris was living in a Cross Keys Homes tenancy in Peterborough, where he had lived since July 2000. As a result of his anti-social behaviour, his neighbour reported threatening behaviour and harassment, the Neighbourhood Manager (Anti-Social Behaviour) (NMASB) contacted the Team Manager, Peterborough Adult Social Care (ASC) Adult Locality Team (TMALT). It was suggested that Chris be considered for supported accommodation. Chris had recently been discharged from hospital.

In August 2015, an assessment under s9 of the Care Act 2014 was completed by a Social Worker and a care package was agreed. Physical health issues, social isolation, neglect of the home environment and poor self-care were noted. The care package was to be provided by the Longhurst Group from the 5th October 2015 and Chris was to move to supported accommodation on the 7th September 2015 in Peterborough.

At the end of December 2015, the Longhurst Group's Service Manager contacted a Social Worker to ask that Chris be seen by a psychiatrist as he was having disturbed thoughts and shouting at voices. There is no record of the request being acted on, although it is recorded in February 2016 that Chris's medication had been changed.

In April 2017, a safeguarding concern was raised by the Police but did not proceed to a s42 Enquiry. Chris had threatened to jump from a window, resulting in the Police and the Ambulance Service attending. Chris's newly allocated Social Worker attended with a support worker. It was noted that Chris was being evicted from his accommodation, which was described as being "in a poor state" and that both the Longhurst Group and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) "were at fault for not picking upon the deterioration", the result of which was that Chris was placed back in general needs accommodation rather than a supported housing placement.

In March 2019, the Police were asked to undertake a welfare check at Chris's address after he had informed a pharmacist that he was suicidal. He advised them that he was hearing voices but had no intention of harming himself. He was waiting for an ambulance and his Social Worker. He was taken to Peterborough City Hospital, where he was referred to the Acute Psychiatric Liaison (APLS) and seen by a Nurse clinical specialist, who discussed getting support from his social worker and a review of his psychotropic medication. It was planned to more closely monitor Chris's compliance with his prescribed medication and to encourage his engagement with drug and alcohol services.

In May 2019, after a significant period in temporary accommodation after his placement in Supported Housing had failed, Chris moved to his final address, a general needs tenancy with on-site weekday staffing. This was thought to provide the best opportunity for Chris to sustain a general needs tenancy.

Between January 2018 and January 2021, Chris had eleven contacts with Herts Urgent Care, the Out-of-Hours service, and between July 2016 and November 2021 twenty contacts with the East of England Ambulance Service. The majority of these related to constipation and did not result in any admission to hospital.

In June 2020, Cross Keys Homes' Supported Housing Manager carried out a joint visit with Chris' social worker; photos of the property were taken, which was described "as in an unhygienic state" and concerns were recorded about the presence of flies and rotting food in the property as well as human faeces on the floor.

In November 2020, the local Multi-Agency Risk Management procedures (MARM) were initiated due to concerns about Chris's physical health, two Category 3 pressure ulcers and self-neglect. The following Action Plan was agreed, the District Nursing Service (DNS) would visit three times a week, Social Worker would visit with the District Nurses to discuss a hot meals service, the current care package would continue and the DNS would pursue a referral to the Community Dietician and his GP was asked to make a home visit to assess Chris's physical health. There is no reference to integrating the resulting agreed Action Plan with the CPA, process, the s117 process, the review process of his assessment under the Care Act or the Safeguarding Procedures.

In November 2020, Chris was admitted to Peterborough City Hospital as a result of rectal bleeding. He was taken by ambulance on the 24th November 2020 but discharged himself against medical advice; the following day he was persuaded by his social worker to return to the hospital and he was admitted. While he was in hospital, a Safeguarding of Vulnerable Adults form (SOVA) (now called an Adult at Risk form (AAR) was raised with the Safeguarding Team within PCH on the basis of Chris's category 3 and 4 pressure ulcers, but this was not forwarded to ASC as they were not considered a safeguarding concern and were being managed within the hospital.

The SOVA was an internal alert system trust staff used to inform the safeguarding team of a safeguarding concern of an adult. Current criteria mean now that multiple pressure category 1 or 2 ulcers or any single category 3 or 4 pressure ulcer meets the threshold for an adult social care referral and would be now be referred.

In December 2020, a MARM Review was held; concerns continued about Chris's self-care, in particular with regard to the pressure sores which he removes the dressings from and sticks his fingers into, his failure to keep health appointments and his wish to cease receiving hot meals as previously arranged. It was agreed the GP Practice would refer to the DNS for a one-off welfare visit to change the dressings if Chris misses three consecutive appointments. DNS had previously discharged Chris as he wasn't complying with his treatment regime.

At the end of December 2020, Chris was admitted to PCH by ambulance after a 999 call from his GP with "infected buttocks." It was noted that Chris was "very frail for age", that he would need a referral to the DNS on discharge, that he was "under the local community mental health team" with a diagnosis of schizophrenia and a history of alcohol and substance misuse. While in hospital, Chris declined a social care assessment, a referral to ASPIRE, a local substance misuse service, and any input at home to treat his pressure sores.

In early February 2021, a review under the MARM procedures agreed four key points: a safety plan should Chris miss response to an individual's situation three consecutive DN appointments; that Chris be weighed weekly at the GP Surgery, a colonoscopy appointment be made and work with Chris around nutrition continue. The colonoscopy appointment was made and Chris was admitted to PCH in mid-February when it was carried out. The above actions were to be reviewed in 6 weeks.

Between February 2021, when Chris registered with a new GP Practice due to a change of address, and November 2021 inclusive, there are more than twenty recordings of "Complex wound care enhanced service administration" but with no detail of the contact; there are also at least nine occasions where it is recorded that Chris had missed two or three appointments with the DNS. There is no record of Chris being weighed. There is no record of the MARM meeting being reconvened, though a s117 review is recorded being held in March 2021. There is also a "Professionals meeting" recorded being held in August 2021 which considered Chris's pressure

sores and his awareness of the consequences of them not being treated; it was "felt he had capacity regarding this. No alternative solutions to missed appointments".

Appendix 2 - Agency Involvement during the review period

In January 2022, Chris refused to go for his GP appointment saying he was too busy. He thought the Care Worker had come to take him shopping. A joint visit between his social worker and GP described Chris as more lucid and less confused, in a better physical condition having possibly put on some weight. Chris also raised issues with his PIP payments which the Social Worker agreed to support with. They agreed Chris "has capacity to make decisions regarding health interventions but wished to discuss other options as they were concerned that Chris' physical condition may worsen".

Chris refused to attend an appointment at the City Care Centre claiming his pressure ulcers were "healing on its own" and that he had already booked a taxi to go in to town. The Care Worker had informed the City Care Centre and later that day Chris showed them some shopping they had done in town.

At the end of January, Chris told his Care Worker that he was hearing voices and that his medication wasn't working. Chirs was advised to continue taking his medication and was reminded of his appointment with the practice nurse. Chris again refused to go saying he was too busy. Chris was advised by his Care Worker and Social Worker of the importance of keeping his appointments.

In February, the Police were contacted by a neighbour reporting that Chris had been knocking on his neighbours' doors, shouting and threatened them. The neighbour did not press charges as they understood Chris had mental health problems. The officers heard Chris shouting and talking to himself but did not speak to him. The next day, a Psychiatrist, Social Worker and GP were asked by the Longhurst Group for an urgent visit to Chris as he was having worsening hallucinations, talking about "God's punishment", having been raped and banging on neighbours' doors. He was also alleged to have posted faeces through his neighbour's letter box which Chris denied. Chris was described as "verbally hostile but not threatening".

At the end of February, during a home visit, Chris informed his social worker that his pressure ulcers had healed but agreed to see a nurse to review them. Chris also shown a lump on his calf that he said he had for about two months. The GP referred Chris to the Joint Emergency Team (JET) which supports those with long-term conditions to review the leg swelling. It was assessed that the swelling was due to Chris wearing tight socks and there were no features of Deep Vein Thrombosis (DVT) or cellulitis identified.

In March 2022, a Care Worker and Social Worker carried out a joint visit and noted Chris "appeared clean and tidy and had washed his hair. Chris continues to hear voices and referred to the 'witch' former neighbour" At Chris' request a face to face visit with the GP was arranged.

The following week, the social worker was informed by Cross Keys Homes, that a shop worker reported Chris was 'quite intrusive' to them, shouting and pointing in her face. Another resident had also reported that some people had been making fun of Chris in the foyer". It was also reported that Chris believed a previous neighbour is practising witchcraft and is in love with him but he finds her repulsive".

Chris called 999 saying he has heart problems, palpitations and difficulty breathing. When the Ambulance crew arrived, they found Chris in bed complaining of left-sided chest sensations that feel as if something is eating away at it. Chris described voices in his head telling him there

are worms inside him and that he has covid. The Ambulance crew completed a physical examination and advised the only way to rule out a cardiac arrest is to have bloods taken at the Hospital. Chris understood this, and despite the risk of further, possibly fatal event id he stays at home, he chooses to do so. The crew called the clinical advice line before ending intervention.

Chris failed to attend an appointment for various health tests with his GP which was later rearranged but Chris also failed to attend. The following day, Chris called 999 as he was worried he was having a heart attack as his heart was racing after drinking energy drinks. A crew attended but symptoms had ceased when they arrived and completed observations. Chris wanted to stay at home and was assessed as having capacity to make that decision. Chris advised his Social Worker that he is hearing voices telling him distressing things such as he has been raped; he is not sleeping well and drinking more alcohol.

Chris called 999 complaining of chest pains and saying he was COVID positive. A crew attended and transported him to the hospital however Chris walked off before he could be seen against the advice of the crew, after having to wait outside due to capacity issues.

Towards the end of March, Chris' brother called the Social Worker saying Chris has no money and thinks his benefits have been stopped. The Social Worker advised Chris that his bank account had been closed because of fraud. It was noted that he had forgotten withdrawing large sums of money in the past and agreed to be supported by a Care Support Worker to check his bank account.

At the end of March, Chris called the ambulance service seven times, saying he was on the floor having fallen. A crew attended and was advised that Chris had fallen and found mobilising difficult. His legs were very painful and his chest was sore. He was taken to the Hospital where he was diagnosed with a small blood clot and discharged home on the Pulmonary Embolism pathway with an inhaler and for follow up with his GP. The following day the Social Worker spoke with a Care Worker to advise that Chris had said the voices were so bad he had been banging his head on the wall. The Care Worker advised there were no marks on Chris' head. A home visit by a Section 12 approved doctor was arranged.

During April, Chris call 999 as he had been sick the night before and coughing up blood. A crew attended but didn't take Chris to the hospital. He was advised to go too A&E if it gets worse. Later that day, Chris swore at one of the Care Workers and declined to take his medication saying he can make his own decisions. Chris later phoned to ask for his medication and another Care Worker returned to do so but saw Chris spit the tablets out. The Care Worker advised him it was important he took the medication but he refused and asked them to leave.

A couple of days later, Chris was taken to the Emergency Department by a Social Worker as Chris was coughing up blood. Following tests and an x-ray, it was suspected that Chris had a blood clot. He was prescribed blood thinners by the Hospital but he lost the prescription. Chris refused to attend a follow up appointment for a scan. His Care Worker advised him of the importance of attending his appointment and contacted his Social Worker who repeated the advice but Chris terminated the phone call and continued to refuse to go as he didn't have the money for a taxi back. Later that day Chris showed the Care Worker the new phone he got from town that day. Chris spoke with his Social Worker about his refusing to take his anti-psychotic medication stating that it was his decision and he didn't need someone watching him take it. He also stated the medication wasn't working and the voices were worse than ever.

Chris informed his social worker that he had been to Hunstanton. He'd jumped off a ledge, bumped his head and lost consciousness; when he regained consciousness, he returned home. He was advised but refused to go to A&E. A Social Worker and a Section 12 approved doctor

made an “urgent home visit”. Chris spoke about going to Hunstanton but denied jumping off a ledge, said he’d just fallen over. He said he heard voices telling him to go to other town, particularly hearing the voice of a “witch” called Louise. He was also described as “thin”. An ongoing concern was note about Chris’ mental health since the change in his medication in January. It was agreed to refer Chris to the Crisis Resolution Home Treatment Team (CRHTT) as the least restrictive option “to monitor risk, medication concordance and for intensive support”. The CRHTT received and triaged the referral that day and arranged to visit Chris the following day. When CRHTT visited they found “his current presentation and needs do not meet the threshold for hospital admission or home treatment. No immediate crisis therefore no role for CRHTT” The outcome was to ‘refer back to the Peterborough Adult Locality Team (PALT)”

A week later a Care Worker visited Chris and described him as looking unwell and with low mood; Chris advised that he had fallen off a building and landed on his head when he had visited Hunstanton a few days previously. The Care Worker contacted the Social Worker to advise them and they were unaware of Chris visiting Hunstanton as staff had been visiting him three times a day and there were no signs of any injury. The Care Worker asked if there were any plans to assess Chris’ mental state and the Social Worker replied that Chris had told them he’d attempted suicide and that he’d fallen over. They advised that they would support Chris to attend the GP for blood tests and an ECG to see if depot injections were suitable to help with his mental health.

A joint visit was held a few days later with a Psychiatrist and Social Worker who noted that Chris appears to be having difficulty with personal care and reporting disturbed sleep, hearing voices and eating less. CRHTT contacted Chris that evening to agree a safety plan. It was documented that Chris demonstrated capacity throughout the phone call, and therefore there was no reason to doubt his capacity.

At the beginning of May 2022, Christ contacted the Duty Doctor about bed sores that he would like dressed. An appointment was made for Chris with the Practice Nurse. The following day, Chriss called 999 complaining of back pain as a result of broken vertebrae from a few years ago and was unable to sleep. Chris complained to his Social Worker that his pressure sores were worse. The Social Worker spoke to the GP with Chris’ agreement and advised that Chris was mentally unwell and this was deteriorating and he wouldn’t be able to get to the surgery.

A week later, the Social Worker visited Chris and went with him to purchase a new mobile phone.

Chris called 999 saying he was thinking of killing himself. A Joint Review Ambulance Car, staffed by a Police Officer and a Mental Health Practitioner, attended and found Chris alert and orientated. He was deemed to have capacity and declined physical observations. He said he was increasing hearing voices telling him to harm himself. He had placed a blanket and a pillow on the floor in case the voices told him to hit his head on the floor. He wanted to feel safe and agreed a safety plan with the Mental Health Practitioner, namely that he will go to bed and ask his neighbours to contact 111 or 999 if he is unable to cope, as he doesn’t have a phone. He asked the crew to let “his team” know about the call out and they assured him they would.

The following day Chris told the Care Worker that the voices had told him to put his money in the washing machine so he couldn’t spend it. He asked if they could keep it in the office for him. The Care Worker said they couldn’t but would ask the Social Worker to see if they could help. It was agreed they would hold a small amount of money for Chris, giving him small amounts each day, on the basis that Chris said that the voices were telling him to throw his wallet full of case outdoors. A Community Psychiatrist Nurse noted that Chris had thrown his phone down the toilet and care staff had helped him buy another. He presented as tired, frail and still hearing

voices. It was also recorded that "suspected aneurysm but declining scan". The Community Psychiatric Nurse also noted that Chris was wearing a dirty T-shirt and a pair of tracksuit bottoms that were too big. He had bare feet, long-hair tied back in a ponytail, long dirty finger nails and nicotine stained fingers. He made no eye contact and kept his head down.

Chris called 999 a number of times over the next few days, the first saying his sight had gone blurry and that he needed eye surgery, the other two saying he had an irregular heartbeat. When the ambulance crew attended, his heartbeat had retuned to normal and the crew left when a Care Worker visited. The Care Worker noted several cans of Red Bull on the floor and he had been advised earlier that day to reduce his intake of energy drinks.

The Ambulance Service was called again as Chris felt unwell but he refused to be assessed when they attended. At the same time, a Community Psychiatric Nurse and Specialist Mental Health Nurse Practitioner brought forward an appointment after Chris rang them saying "he didn't think he could keep himself safe". Chris was demanding to be admitted to the Cavell, thought the staff were calling him a liar, irritable and angry. He was unwilling to engage in any way unless an admission was facilitated. He was asked why admission was so important and preferable to being treated at home but he was unable to give an answer, became irritable again and threatened to end his life. They would then realise that they "should have admitted him to the Cavell". He said "What makes you think I don't need to be admitted to the Cavell? I keep telling you I do" and he then got up and left the room.

Towards the end of May 2022, a Social Worker and Community Psychiatric Nurse undertook a joint visit and noted Chris' mental state was deteriorating. He confirmed that the voices are not asking him to burn down the flat anymore but spoke about pulling down his trousers and defecating in the street. He was advised to reduce his intake of energy drinks as they will cause insomnia, advised to continue taking his medication when the carers give it, to stop drinking alcohol and to try and practice the techniques identified by the Basic Personality Inventory which had been completed by CRHTT such as daily planning. While giving Chris his depot injection, they noted two long-standing pressure ulcers on his buttocks appeared sore and red; they asked if he would attend an appointment with the Practice Nurse and he replied he might but he was too busy at that time. Throughout he appeared quite sarcastic during the visit, and was argumentative and irritable when questions were being asked. Chris stated no-one is listening to him about his need for admission to hospital. His poor engagement with CRHTT was discussed and that they will be discharging him back to PALT and he was encouraged to comply with his medication, make plans for the day and keep himself busy in order to distract himself from the voices. Chris was left details for First Response Service (FRS) which he can access out of hours. Chris then stated "right are we done now ladies" indicating he wanted them to leave.

At the end of May, following a home visit by the Social Worker and Community Psychiatric Nurse who noted that Chris' pressure sores appear to be healing and no other concerns noted, Chris called 999. A Joint Review Ambulance Care attended and found Chris alert and orientated. Chris refused any observations and the crew noted that they had seen Chris several times with the same presentation of hearing voices which he has coping mechanisms for. He didn't want to go to hospital but wanted reassurance that the voices won't cause his death. Early June, Chris was reminded of his GP appointment that afternoon but Chris refused to attend.

At the beginning of July, the police received a call from staff reporting that Chris, who had been in the office very agitated, saying he was dying. He had approached another resident asking for help then punched them three times to the head. Chris said the voices in his head told him his neighbour had raped him and told him to punch his neighbour. Chris refused to take his medication against the advice of this Care Worker and also the offer to seek support from the

FRS as he preferred to wait for the Police. He later admitted that his neighbour hadn't raped him and the voices were telling him untruths. The Police recorded a crime of assault and the situation was resolved out of court with an anger management course.

A couple of days later, a Care Worker visited Chris and noticed he had bought four boxes of paracetamol. Another Care Worker had already previously taken several boxes of paracetamol from Chris over the weekend. Chris said he had bought them for his headaches and refused to hand them over. Later that evening, Chris was said to have felt mentally unwell and wanted to go into hospital. The following day, a Social Worker visited Chris and noted that he looked unwell, possible high heart rate and unshaven. Chris said he'd had no sleep overnight or eaten for two or three days, and had unpaid council tax and TV licence. NHS 111 was spoken to and agreed a taxi would take Chris to ED as there was a difficulty getting an ambulance but he returned after thirty minutes as he didn't want to wait to be seen.

During July, a home visit by the Social Worker noted Chris' mental state appears to be deteriorating, consuming energy drinks, alcohol, evidence of cannabis use, buying boxes of paracetamol and thoughts of harming himself. The Social Worker made a referral to CHRTT but the referral was declined saying the PALT psychiatrist should review Chris. It was also recorded that Chris had thrown his phone through a window as the voices told him to do so.

Towards the end of July, Chris was given an anti-social behaviour warning for abusive behaviour towards his neighbour putting his tenancy at risk. A home visit by the Consultant Psychiatrist and Social Worker also noted poor self-care, long beard and hearing voices in his head telling him he was raped by his neighbour. It was also reported that his pressure ulcers are worse but Chris declined for them to be observed. The following day, Chris called the police in the early hours alleging he had been raped, but he then hung up and didn't respond to being called back. The police attended Chris' address but got no reply. They rang Chris again later in the morning, and he said he wasn't sure if the rape had happened. The police attended again in the afternoon and initially saw Cross Keys Homes staff who said they were concerned for Chris as "they didn't feel he was receiving appropriate care. They stated mental health professionals did not feel he reached the threshold for residential treatment." The Police spoke to Chris who was very confused and asked to be admitted to hospital, saying he hadn't slept for seventy two hours. He declined to engage any further with the rape investigation, providing no details of the alleged rape and gave difference names for the alleged rapist. The police spoke with a Social Worker who said they were trying to find "a secure Mental Health bed for Chris". An adult safeguarding referral was completed and reviewed by the Police MASH but, in line with standard practice, not forwarded to Adult Social Care as they were already involved and were aware of the allegation. A crime of rape was recorded and clothing taken for possible forensic analysis but Chris told the Social Worker the next day that he didn't want to pursue the allegation.

A home visit by an Approved Mental Health Practitioner and Social Worker spoke with Chris who repeated his allegation of rape by his neighbour, advising that he had told the Police, and asks to be admitted to the Cavell Centre. They advised him that they "were not the decision makers but could request an informal admission" and advised that he engage with his support package. It was recorded that they considered Chris to have the capacity to request an informal admission, it had previously been considered that he didn't, though no formal capacity assessment was undertaken, and therefore they did not complete a Mental Health Act assessment. The Approved Mental Health Practitioner was to follow this up and tried to contact the Consultant Psychiatrist and GP to discuss the situation but neither were available.

Towards the end of July 2022, a Mental Health Practitioner visited Chris and noted that he was unkempt and not maintaining his personal hygiene. The flat was dirty and very smoky, the floor

was covered with alcohol bottle and Chris avoided eye contact and was hearing voices. The following day, Chris called 999 having smashed a bottle over his own head. Chris ended the call, and when the call handler rang him back, Chris told them to stop ringing him.

At the beginning of August, Adult Social Care had received a safeguarding referral from the social worker on the basis of Chris having been raped by his neighbour. The MASH gathered further information and identified that Chris had withdrawn the allegation of rape, that his mental health was declining and he had asked to be admitted to hospital and a "Mental Health assessment was underway". The adult safeguarding enquiry was not progresses, and Chris was referred to existing support within Mental Health services.

The following day, the Police were attended Chris' address after reports of a party and fighting in his flat; he was in fact on his own, but intoxicated and sitting on the floor with packs of paracetamol and a notepad saying "my will, I died tonight". He seemed in a poor physical condition and said he wanted to go to the Edith Cavell Centre due to his schizophrenia; he said he'd spoken to the CHRTT but there were no beds. The Police noted that "his mental state is deteriorating, he seems to be abusing alcohol and self-neglect." And "I do believe there is high self-neglect." The Police called for assistance from the Ambulance service who attended. He presented as alert and said he didn't know why an ambulance had been called. He denied any suicidal intentions, admitted being alcohol dependent and being in contact with mental health services but declined any assessment or conveyance to hospital. He gave no reason to query his capacity, was calm and polite to the crew and, as the crew prepared to leave, went out to get his breakfast and more alcohol.

The Care Worker visited Chris with the CHRTT to administer liquid medication as it was noted that, despite being shown several time how to do so, Chris still needed support to "draw up the liquid medication". A couple of days later the Community Psychiatric Nurse visited Chris to assess his "medication concordance". It was noted that his room was chaotic, with "all types of belongings on the floor including microwaves and electronic wires/leads" and he had been hearing voices in his head all day.

The following week, Adult Social Care received a referral from the Police based on their attendance at Chris' flat at the beginning of August. Further information was gathered by the MASH and it was deemed that no abuse had taken place. Chris' social worker was informed that the referral had been closed as the concerns raised by the Police related to Chris' poor mental health.

The following day, a Social Worker, a Consultant Psychiatrist and two members of CRHTT visited Chris; the flat was described as clean and tidy, Chris was "bright in mood" but talking of witchcraft and voices telling him his neighbour was harming him, though he knew this wasn't true. The outcome were that Chris was discharged from CRHTT due to his inability to manage his medication in liquid form and having to return to taking it in tablet form, PALT to continue to stress the importance of taking his medication and to consider depot injections as an alternative.

Towards the end of August, when talking to a Social Worker, Chris was calm and chatty but still hearing voices and wanting to be admitted to the Cavell Centre. The following day the Community Psychiatric Nurse noted that while a depot injection was given a "small patch of scabbed/healing pressure sore remains on a lower part of his buttock"

During September 2022, concerns were raised with the GP about Chris' "puffy swollen face". It was suggested a referral to Aspire Drug and Alcohol Service as a swollen face may be due to excessive alcohol consumption but Chris declined this, saying previous contact with Aspire had

little success and he would reduce his alcohol intake himself. When asked by a Care Worker, Chris said he was drinking roughly one and a half bottles of wine a day. When it was suggested that he drink more water, he laughed.

Towards the end of September, the Social Worker rang Chris about his GP appointment that day; Chris said he had to go to the bank and couldn't keep the GP appointment, despite pain in his legs. The social worker offered to take Chris to the appointment but he declined. The social worker recorded they had no reason to doubt Chris' capacity to make this decision.

The Community Psychiatric Nurse, Chris' Care Coordinator, and Consultant Psychiatrist visited Chris with a Social Worker attending virtually to complete a review. Chris was more amenable towards the end of the review and agreed to cut down on his alcohol consumption, to see his GP, and increase his water intake. He generally appeared to have the capacity to make informed decisions on this matter. An appointment was made with his GP for a physical health check mainly due to his swollen face to assess for other potential causes. It was agreed on the basis of his current presentation and needs he did not meet the threshold for hospital admission or home treatment. His symptoms appear to be chronic and the voice he hears has been there for many years. He does not like his current accommodation and wants to be moved; he is also wanting to go on injection. There is no immediate crisis and therefore no role for CRHTT. The community team would explore medication options with Chris, who has in place three daily carer visits who monitor his medication concordance. Chris stated he would prefer to have his appointment with his consultant brought forward and does not feel CRHTT would do much for his as they cannot get him admitted to the Cavell Centre.

At the beginning of October, the social worker called to take Chris to his GP appointment but Chris said he was at the bank opening a new account and refused the Social Worker's offer to pick him up. The Social Worker recorded that Chris understood the risks of not having his physical health checked but was prioritising other things. A few days later, the Social Worker attempted to take Chris to another GP appointment but he refused to go as he said he would reduce his alcohol consumption which was causing his swollen face. He continued to decline, despite being advised of and understanding the potential risks. Recognising that this was the second cancellation and that he was prioritising other things than his physical health, no concerns relating to capacity recorded.

Towards the end of October, Chris complained to a Health Care Assistant that his face was swollen and he wasn't sleeping. A Community Psychiatric Nurse visited Chris and noted that he was drinking twenty units of alcohol a day; a capacity assessment was completed that resulted in Chris being deemed to have capacity regarding his alcohol consumption and the ensuing risks.

At the beginning of November, a Consultant Psychiatrist contacted the GP to book him an appointment due to his swollen face. He was advised to keep his phone on so he could be advised of the date and time of the appointment. The GP was unable to contact Chris as his phone was turned off. The following week a face to face appointment was made but Chris declined and another appointment was made. The GP tried contacting Chris six times to remind him of his third GP appointment but he didn't answer so messages were left for him. The Community Psychiatric Nurse visited Chris, who said he hadn't felt well enough to attend his GP appointment and it had been raining. When the offer was made to rebook, Chris said he would let them know when he felt well enough to attend. When care staff came into his flat, he slammed the door in their face and said he wasn't going to attend the GP.

Towards the end of November, the Social Worker noted that cleaners reported that Chris is drinking alcohol excessively and that his flat smells of cannabis. The Community Psychiatric

Nurse visited Chris to carry out a welfare check and to administer a depot injection; they noted that his face was puffy and that he agreed to a referral being made to the Dual Diagnosis Outreach Team (DDOT) to support his to see his GP. A Care Worker reported that Chris had run out of Tramadol due to a decrease in the amount prescribed from 56 to 28 tablets a week. the Care Worker queried this with the Pharmacy and GP and it was agreed the duty GP would be asked to amend the prescription. As a result, Chris refused all medication the next day.

In December, the Social Worker, Consultant Psychiatrist and Community Psychiatric Nurse visited to undertake a s117 review. Concerns were raised about Chris' physical health It was noted there was a "marked deterioration on overall health with poor self-care, visible weight loss and poor food and fluid intake. Chris had delusional beliefs including an alien moving into his body causing the pain, stating Satan and aliens were talking to him. He denied thoughts of harming himself or others and declined to go to ED and was deemed to have capacity regarding his physical health. Carers reported a smell of cannabis and the cleaner reported seeing little bags of cannabis. Excessive alcohol intake was noted as was heavy smoking. It was agreed with Chris that a nurse from the GP would call later to take bloods, which they did.

Later in December, the Community Psychiatric Nurse carried out a welfare check as a result of carers advising that Chris wouldn't let them in to his flat. Chris presented as pleasant but was hearing voices; he asked for a depot injection that day but accepted it wasn't due until the end of December. He said he hadn't let staff in because he "was sick in the head" but felt better now He'd drunk a bottle of wine that day. The following day, the social worker made multiple phone calls to Chris which went to voicemail as his phone was turned off. The GP also attempted to contact Chris by phone in response to a request from the Mental Health Team but these were unsuccessful and went to voicemail.

At the end of December, a Mental Health Practitioner gave Chris his depot injection where it was noted that he was smoking and drinking his second bottle of wine at 11:40am.

At the beginning of January 2023, it was noted that Chris' Liver Function blood test showed raised enzymes and low albumin. The proposed course of treatment was the gradual reduction in his medication to minimise the impact on his mental health.

The following day, the Care Workers noted a bag of cannabis in Chris' flat with more empty bags on the floor. Chris said "it was spice and none of their business". In addition, it was noted that Chris had accused his cleaners of stealing from his flat; they are now not prepared to go into his flat, which they describe as in a poor state and that he leaves money around. The Social Worker visited Chris and advised that the cleaners had reported Chris telling them he was using cannabis and Spice, which he denied, stating he hadn't taken any drugs for over 18 years as he was aware that drugs would make him more paranoid He said he continued to drink excessively and the Social Worker submitted a Safeguarding Concern to the MASH but the MASH informed the Social Worker advising there is no role for safeguarding as Chris has alleged he had been the victim of a crime and should report it to the Police. The Social Worker advised the MASH of Chris' deteriorating physical and mental health and that these may have triggered the allegation. The Social Worker also advised that Chris had made similar allegations against four other cleaning companies, all of which had been unfounded. A member of the MASH attempted to phone Chris but was unsuccessful.

During January, it was noted that Chris was verbally abusive and showing persecutory ideation against the NHS; he said he hadn't slept much and was on edge having drunk a lot of energy drinks.

The following week, it was recorded that Chris had been refusing his medication throughout the week, being verbally aggressive with staff and talking to himself. A Community Psychiatric Nurse visited to give him his depot injection where Chris showed them a pressure ulcer on his foot which he declined to have a GP appointment made for but agreed to a home visit. His non-compliance with medication was discussed and he said he is sometimes in a bad mood when the carers call, but he was aware of the negative effects of not taking it and he agreed to do so in future.

A referral from the Mental Health Team to the District Nurses was sent for an assessment of a stage 4 pressure ulcer on Chris' heel which he couldn't walk on was made. The District Nursing team sought confirmation that Chris is housebound as their criteria requires him to attend the surgery if he wasn't; they emphasised that the last time he was open to them, he wasn't housebound and was often out when the District Nurses visited. When the District Nurses visited to treat Chris' pressure ulcer, Chris became agitated, and started hallucinating saying "everyone has aliens in their feet". He told the District Nurses "to leave multiple times, becoming angrier." It isn't clear if they treated the pressure ulcer. They informed Chris' Social Worker that, as Chris had capacity, wasn't concordant and wasn't housebound, they would discharge him from the service. Chris' Social Worker suggested a professionals meeting may be required due to his decline in mental health and he previously had skin damage that developed into pressure sores that became severe.

At the end of January, Chris failed to keep an appointment to review his medication. The GP tried to call Chris several times but they went to voicemail. It was also recorded that Chris had refused his medication and was difficult to engage. Staff were having to bring food from the shop as he couldn't go himself. A joint visit from the Community Psychiatric Nurse and a colleague from the Peterborough Adult Locality Team noted that the flat had been "trashed" with bottles littered about. Chris was advised the visit was to observe his feet and check his welfare but he told them to leave as he was fine and none of their business.

At the beginning of February, a routine visit by Consultant Psychiatrist and Social Worker noted that Chris' mental state had deteriorated, he was hostile and agitated, not complying with his medication, had stage 2-3 pressure sores on his left foot and three grade 1 pressure sores on his right foot which he refused treatment for despite being aware of the risk of sepsis. Poor self-care was evident and he refused input from CRHTT. It was discussed with an Approved Mental Health Practitioner that while there was a need to rule out any physical health reasons for Chris' behaviour, particularly any infection from the sores on his feet, he wasn't engaging with services to facilitate this, and his mental health had deteriorated in the last week. District Nurses had assessed Chris as having capacity regarding his poor engagement with them and he was aware of the risk of sepsis. He was not acutely unwell, so an ambulance hadn't been called, the GP wouldn't visit and a referral to the JET team was inappropriate. In the view of the GP, if Chris wouldn't engage with services regarding his physical health, then an assessment under the Mental Health Act should proceed as Chirs was a risk to himself that couldn't be managed in the community. If Chris continued to not engage with physical health services, the AMPH team should be advised to discuss further follow up.

On the 7th February, Chris was admitted under s2 of the Mental Health Act for an assessment as opposed to treatment (under s3). On admission to the Cavell Centre, staff raised concerns about his physical health: he was dishevelled, the bottom half of his body was uncovered, which the Advanced Mental Health Practitioner covered with a blanket, he was responding to unseen stimuli, yelling he was "God Almighty" and claiming he was being raped though nobody was near to him. He refused to accept any treatment other than brain surgery. Pressure sores

were noted to both feet. Arrangements were made to transfer him to the Emergency Department at PCH.

Upon arriving at the ED, it was recorded that Chris had sepsis and suspected pneumonia, currently under s2 at the Cavell Centre and refused to have oxygen or have the wound to his left foot treated. He was transferred to the Medical Short Stay Unit for further treatment. Chris was later transferred to the ward where he remained. Bloods were taken and he was given IV antibiotics. Chris asked staff if he was being experimented on, or if staff were trying to make him an alien, but did agree to a medical examination. The plan was for Chris to remain in ED until he was off oxygen and his ECG had been reviewed due to concerns about his heart function. It was identified that he lacked capacity regarding medical care. A week later the Hospital applied for a Deprivation of Liberty Safeguards (DoLS) on the basis that Chris lacked capacity to make decisions regarding his medical care and treatment.

Towards the end of February, a safeguarding concerns was raised by the Named Nurse for Safeguarding Adults and Social Worker on the basis that Chris didn't have "access to appropriate care and treatment associated with his physical health needs via his GP and community nursing team" prior to admission to the Cavell Centre. After gathering further information, it was decided to escalated to a Section 42 enquiry under the category of Neglect.

As part of the Section 42 Enquiry, the social worker attempted to visit Chris in hospital to establish his views and wishes as per Making Safeguarding Personal but was unable to do so as Chris was too unwell. At the beginning of March, the Social Worker visited Chris to discuss the Section 42 Enquiry, but as Chris was physically very unwell and disoriented, it was considered inappropriate to continue and decided to refer Chris for an advocate.

Chris died 3 days later.