RBSAB
ROCHDALE BOROUGH
SAFEGUARDING ADULTS BOARD

Rochdale Borough Safeguarding Adults Board

Safeguarding Adults Review

Adult I

Overview Report

Presented to the Rochdale Borough Safeguarding Adults Board on

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1. Introduction

1.1 This review considers the sad circumstances of the death of Adult I in February 2022.

1.2 Adult I was a gentleman of British/Pakistan ethnicity who was 55 when he died. Adult I had lived in Pakistan for a period of time when he was a child, returning to the United Kingdom (UK) when he was still of school age. He went on to leave home at 16 and family report he had been employed in several roles after leaving school, working in different parts of the country during his adult life.

1.3 When speaking to professionals Adult I reported that at times relations with his family could be strained, on occasions due to his own behaviours. He struggled with his mental health and in middle age he developed some long-term health conditions that he found difficult to manage. He had received support from several agencies prior to his death, his engagement with these was also at times sporadic.

1.4 This Safeguarding Adult Review (SAR) considers the circumstances surrounding Adult I's death. The SAR will examine the systems and multi-disciplinary support that surrounded him to identify any learning that could improve services to others.

2. Context of Safeguarding Adults Reviews

2.1 The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. The SAR is conducted under Section 44(2) of the Care Act, based on Adult I's long standing mental and physical health problems, and the absence of any agency involved with Adult I to make an adult safeguarding referral for 'self-neglect', or the convening of any multi-agency meeting to discuss a multi-disciplinary risk assessment and action plan.

2.2 Rochdale Borough Safeguarding Adults Board (RBSAB) commissioned an independent author to carry out this review. The independent author is Michelle Grant who is wholly independent of RBSAB and its partner agencies.

2.3 The purpose of SARs is '[to] *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again'*.[1]

2.4 The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity[2]. The principles apply to the review as follows:

[1] Department of Health, (2016) *Care and Support Statutory Guidance Issued under the Care Act 2014*
[2] Ibid

Empowerment:	Understanding how Adult I was involved in his care; involving those close to Adult I in the review.
Prevention:	The learning will be used to consider prevention of future harm to others.
Proportionality:	Understanding whether services offered to Adult I were proportionate to the risk he presented to himself.
Protection:	The learning will be used to protect others from harm.
Partnership:	Partners will seek to understand how well they worked together and use learning to improve partnership working.
Accountability:	Accountability and transparency within the learning process

3. Terms of Reference

3.1 Adult I was the primary subject of this SAR and the report focussed on the time frame between February 2020 and February 2022 when he sadly died. The review aimed to:

1. Establish any learning about the way in which local professionals and agencies work together to safeguard adults.
2. Highlight good practice and share this with the RBSAB.
3. Identify any actions required by the RBSAB to support and improve multi-disciplinary working, systems and practice.
4. Use learning to reduce risks to others.

3.2

Terms of Reference

To determine whether decisions and actions in the case comply with the policy and procedures of the named services and RBSAB:

- What were the barriers to staff not reporting the self-neglect of Adult I into safeguarding adult procedures?
- Examine whether outcomes during the timeframe of the review met the principles of Making Safeguarding Personal
- How well did agencies recognise and address risks surrounding continued non-engagement and cancellation of care packages, whilst respecting Adult I's right to make decisions that others may view as unwise?
- How well was the MCA 2005 utilised in the assessment of Adult I?
- What was the quality of risk assessments, and care planning and were responses appropriate and proportionate to the nature and degree of risk? Were there clear escalation routes?
- Were Adult I's family appropriately involved in the arrangements for his care?

To consider the effectiveness of multi-disciplinary working and service provision for Adult I: ○ What services were in place to support multi-disciplinary working for people with anxiety and depression as well as long term physical health conditions. ○ How well did interagency working and service provision support Adult I?
To examine service provision and wider systems issues that impacted on Adult I: ○ What systems factors enabled or acted as a barrier to meeting Adult I's needs? ○ How does the system support people with anxiety and depression as well as long term physical health conditions? ○ Were peer support models considered to support Adult I in accessing healthcare or to alleviate loneliness?

4. Methodology

4.1 The methodology applied for this SAR combined narrative reports and chronology from each agency with a reflective multi-agency learning event to draw out further detail with some of the practitioners involved.

4.2 Understanding the experiences of those receiving support from agencies is central to learning. The independent author is grateful to 2 of Adult I's brothers for their contribution to this SAR.

4.3 The privacy of the adult and his family this SAR relates to has been protected through use of an alphabetical reference.

Agencies Providing Reports to the Review and Context of Involvement	
Rochdale Borough Council (RBC) Adult Social Care (ASC)	Rochdale Borough Council provided Adult Social Care to Adult I The Council also had commissioning responsibilities to provide community service provision for adults requiring substance misuse treatment, and for care packages based on a needs assessment.
North West Ambulance Service NHS Trust (NWAS)	North West Ambulance Service cover the geographical area Adult I's property was in and responded to calls from District Nurses, and Adult I's carers.
Northern Care Alliance NHS Foundation Trust (NCA)	Adult I was known Northern Care Alliance staff as a result of his attendances at various hospital outpatient clinics, he was also known to their District Nurse Team.
Heywood Middleton and Rochdale NHS Clinical Commissioning Groups	The CCG provided information about the role of Adult I's GP Practice in his care. The CCG also had commissioning responsibilities to develop community service provision. They became part of the NHS Greater Manchester Integrated Care Board from 1st July 2022

Cherish UK	The care agency provided carers to support Adult I's needs from August 2020 until November 2020.
Homecare For You	The care agency provided carers to support Adult I's needs from June 2021 until his death in February 2022.
Rochdale Boroughwide Housing (RBH)	Provides social housing for rent across the Rochdale area.
Turning Point (TP)	Rochdale and Oldham Active Recovery provide integrated drug and alcohol services, Adult I was referred to them during the period of this review.
Thinking Ahead provided by the Big Life Group	Staff support for people with common mental health difficulties such as anxiety and depression across the Heywood, Middleton and Rochdale area.

Structure of the Report

The report is structured as follows:

- Section 5 provides an insight into Adult I.
- Section 6 gives analysis and learning.
- Section 7 outlines changes made by agencies and their plans for improvement.
- Section 8 provides a conclusion.
- Section 9 makes recommendations for the RBSAB and partners.

5. The Background of Adult I

5.1. Adult I was a man born in the UK of British/Pakistan ethnicity. He was in his fifties when he died. Of the 9 protected characteristics[3] race and religion were applicable to him, however there is no evidence shared with the independent author to suggest that Adult I was discriminated against by any agency based on his race and religious belief.

5.2. The Equality Act 2010[4] describes a disability as a physical or a mental condition which has a substantial and long-term impact on your ability to do normal day to day activities. Records show that Adult I did struggle with a significant number of day-to-day activities due to his chronic pain from arthritis and his anxiety and depression. The act protects people from discrimination in the workplace and in wider society.

5.3. Adult I lived in the Rochdale Borough area in his adult life, he also spent time working in other areas of the country before returning to Rochdale in later life. As a young child he was taken to Pakistan by his parents spending time there before returning to the UK. As a result of this he described to professionals that this led to his struggle with the English language and his literacy. He appears to have had a difficult childhood informing Adult Social Care (ASC) staff that at the age of 16 he left home and spent some time being homeless before being able to secure social housing.

[3] Equality Act 2010 9 Protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
[4] Ibid

5.4. Being homeless at such an early age led his family to believe him to be targeted due to his vulnerability by people who did not have his best interests at heart. One of the brothers of Adult I that the independent author spoke to believes that it was during this time that Adult I began to be exposed to drugs and alcohol.

5.5. Adult I had lived in the accommodation supplied by Rochdale Boroughwide Housing (RBH) from 2014. He was living in a one-bedroom flat as part of a block that had other flats within it. Adult I was housed on the ground floor of the block. In 2014 Police had to break into the flat to gain access to Adult I following a concern over his health, this had led to a hole in the door which was never repaired. The property was also described as having 'bars at the windows' for security reasons.

5.5. Health records evidence that Adult I suffered from long standing physical health problems; arthritis, type 1 diabetes as well as pancreatic insufficiency which impacted on his mental health. Adult I had previously been known to mental health services in 2014 and again in 2017, but was discharged due to lack of engagement in 2017. He had spent a considerable length of time as an adult using cannabis to relieve 'physical pain' he was experiencing. He was also noted to be a heavy smoker and drank to excess at various periods in his life.

5.6. Adult I had family and a friend who would provide some support to him although he was aware that one of his brothers had mobility problems and described his friend as having his own issues resulting in Adult I not wanting to burden others with his own problems.

5.7. When speaking to various professionals Adult I described sometimes difficult relationships with different family members some of which he instigated which resulted in lengths of time when there was little communication between them. He had several friends but as his struggles with his mental health continued these gradually fell away.

5.8. During the timeframe of this review Adult I was referred to a number of hospital outpatient departments for investigations into various health issues including endoscopy due to his significant weight loss over the last year of his life, the diabetic team for support in managing his diabetes, vascular surgeon for intermittent claudication and the cardiology team following an episode of chest pain. Adult I had 'patchy' engagement with these appointments possibly for several reasons: poor mental health, cost of getting to the appointments, understanding the content of the outpatient letters sent to him.

5.9. The social housing Adult I lived in was plagued by a mouse infestation for a significant period of the review timeframe. Despite the environmental health team attending to treat the problem it was not particularly effective as other residents in the flats were leaving rubbish out which attracted the mice back into the building. The impact of the infestation had a significant impact on Adult I's mental health and wellbeing. He had taken pleasure in cooking but the presence of the mice made him anxious that his food was contaminated with mouse droppings and that this was the cause of his nausea and vomiting. As a result, he would decline food prepared by staff in his home, would eat very little and relied on takeaway foods which were both expensive and lacked nutritional value to assist in the management of his diabetes.

5.10. Adult I could be very particular about what he would and would not accept in terms of support both medically and socially and had a very fixed view on where he would like to move to when he was seeking to change his accommodation. He was supported by one of his brothers to bid on properties due to his difficulties with literacy.

5.11. ASC carried out 3 needs assessments on Adult I during the timeframe of the review. On each occasion he was offered support packages following confirmation that he met the criteria for support. The first 2 packages of care were cancelled by Adult I himself citing reasons such as 'he didn't need the help' and 'I can't afford to pay the cost'. The financial position of Adult I was also something that he required support to manage, he cancelled his care package in 2020 citing financial difficulties at the time but was later found to not to have any arrears once his PIP payments were put in place. Other support was offered by ASC, Adult I was referred to both Community Connectors[5] and Motiv8[6] to see if he would engage with these staff.

5.12. Adult I referred himself to Thinking Ahead in 2020. This is a service that provides support to people with common mental health problems and matches evidence-based treatment options in a stepped care model for Improving Access to Psychological Therapies (IAPT). A Psychological Wellbeing Practitioner (PWP) provided Adult I with support with his anxiety and depression throughout 2020/21. He requested 1:1 support rather than group work stating that he found group work challenging and that it made him feel more aggressive.

5.13. Two of the brothers of Adult I who have provided support for this review both felt that the Covid 19 pandemic had a negative impact on their brother's physical and mental health. At the start of the pandemic in early 2020 and again in early 2021 when Covid restrictions were high the contact Adult I was able to have with professional's face to face was severely limited. He had telephone consultations and reviews with his GP and was contacted via telephone by ASC staff during these periods of tight restrictions. He agreed to telephone consultations at the time but later in **November 2020** complained to staff that he felt 'neglected'. When options for contact were limited Adult I may have felt that this was the only choice available to him so he had to agree. Face to face visits by staff did recommence when Covid restrictions allowed this.

6. Analysis and Learning

To determine what analysis and learning can be drawn from the headings identified in Appendix 1

6.1 **Patient factors** (clinical conditions, psychological factors)

Adult I had been a late diagnosis of type 1 diabetes, he struggled to manage this, not always keeping his insulin in the fridge, and occasionally losing equipment to support the administration of his insulin. He described issues with his mental health and lack of sleep making him confused as a lot of his thoughts 'were all over the place'. He had developed a diabetic foot

[5] Community Connectors provide support to people with topics such as health, housing, employment and money management.
[6] Motiv8 supports people aged over 25 who need support to get their lives back on track such as health, alcohol, drugs, and debt.

ulcer which made it both painful and difficult to mobilise. He experienced several falls which caused damage to his teeth and he navigated around his flat by 'furniture walking'.

6.1.1 He also suffered from incontinence both of bladder and bowels, admitting to staff that almost as soon as he had eaten, he would get the urge to go to the toilet. Due to his lack of rapid mobility this resulted in him being doubly incontinent. He stated that he regularly soiled his clothes and was at times washing them in the shower or having to remain in soiled clothing due to a lack of clean clothing that fitted, especially when he had lost weight over 2021.

6.1.2 As previously stated, the mouse infestation in Adult I's property had a significant impact on his mental health, he described to staff that he had thoughts of packing his bags and living out on the streets rather than coping with the mice in his home. He reported that they crawled over him when he slept and urinated on his bed. He stated he was also scared of them and didn't want to go to certain places in his flat when he saw one there in **September 2020**.

6.1.3 In **February 2020** Adult I referred himself to Thinking Ahead, because he had "confusion going on in my head and sleeping problems". He had an initial wellbeing assessment undertaken in **March 2020** by a Psychological Wellbeing Practitioner (PWP).

6.2 Staff factors (personality, cognitive factors)

6.2.1 There is no evidence to suggest that any of the staff who were engaged in supporting Adult I during the 2-year period of this review did not want to try to achieve the best outcomes for Adult I.

6.2.2 At the Practitioner Learning Event staff confirmed that they were aware of RBSAB's safeguarding policies and procedures and the category of self-neglect. Some practitioners were also aware of the Multi-Agency Risk Management Protocol (MRM) protocol but not all. Despite this if self-neglect and safeguarding had been considered most agencies staff felt that the threshold for a referral to ASC was not met under safeguarding procedures, and therefore the MRM was not triggered either as this is only commenced when someone at risk is not engaging with safeguarding procedures.

6.2.3 When letters were sent by the PWP to ASC in **September and November 2020** documenting concerns for Adult I's wellbeing and home circumstances and intended to initiate safeguarding procedures these were not interpreted by ASC to be a 'safeguarding referral' because they were not submitted on the RBSAB's safeguarding referral document.

6.2.4 Adult I asked the PWP for support with help to build a schedule of all his appointments, one of the guided self-help interventions that PWP's deliver is behavioural activation, this is a CBT based intervention that provides tools and techniques to help people create helpful, balanced schedules of routine, pleasurable and necessary activities.
A PWP is qualified to provide up to 6 x 30-minute sessions of Guided Self Help. They are not mental health nurses or social workers and cannot diagnose mental health conditions nor assess for mental capacity. Most PWP work is conducted over the telephone (regardless of COVID adaptations) and so a PWP has somewhat limited exposure to clients.

6.2.5 A multi-disciplinary risk management meeting bringing staff together who were supporting Adult I to share concerns, review risks and share a risk management plan was also not actioned by any individuals despite different staff groups having repeated concerns for Adult I's health and welfare. It was only the PWP who shared information with ASC the GP and his carers in an attempt to gain an overview of how best to support Adult I.

6.2.6 Thought was given by ASC as to whether Adult I had the mental capacity to make the decision to cancel his care package in **November 2020**, but this was not advanced beyond consideration. Only a District Nurse and NWAS staff documented mental capacity assessments on Adult I during the timeframe of the review. The District Nurse in relation to Adult I's ability to give informed consent to his care and treatment in **October 2020**; on this occasion he was found to have capacity to make this decision. NWAS staff completed theirs in relation to his ability to consent to transfer to hospital in **February 2020** when they concluded that Adult I lacked the capacity, there followed a best interest decision to transport him to hospital for medical treatment. Other decisions about his care and treatment were undocumented but concluded that he had the right to self-determination and to make an unwise decision, principle 3 the Mental Capacity Act 2005[7]

6.2.7 When receiving care support Adult I expressed the view that he would prefer to have male carers and was embarrassed by female carers supporting him with his personal hygiene. Whenever possible the care agencies attempted to meet this request. In **November 2020** Adult I informed expressed the view that staff rushed in, supported him with medicines and some cleaning tasks and then were quick to leave.

6.2.8 Nationally it is reported that there are difficulties recruiting in the care sector[8] with high turnover of staff, staff vacancies and maintaining continuity of care. This is not a factor particular to the Rochdale area.

6.3 Task factors (guidelines, policy and procedures, decision aids)

6.3.1 In ASC there is a requirement to undertake a needs assessment under section 42 of the Care Act 2014 of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care. The focus of the assessment is on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve[9].

6.3.2 When it has been identified that a person has needs that should be supported and funded under the Care Act 2014 Chapter 23[10] ASC have a responsibility to offer a direct payment. This allows under certain criteria an individual the ability to employ their own carers. Adult I appeared to have a friend at some point who he could have asked to support his care needs as his personal assistant if the friend had been able and willing. As Adult I had a background of substance use and financial management concerns ASC would consider a managed budget as

[7] Principle 3: Unwise decisions: people have the right not to be treated as lacking capacity merely because they make a decision that others deem 'unwise'
[8] Recruitment and retention in adult social care: a qualitative study
[9] Care Act 2014 (c13): Assessment and Eligibility
[10] Care Act 2014 (c.23): Direct payment

opposed to the default of a direct payment. A direct payment would necessitate a person being able to formally act as an employer of any personal assistant, Adult I would potentially have struggled with this role of 'employer'.

6.3.3 Adult I had 3 needs assessments carried out by ASC during the timeframe of this review, 2 of which were done in person. He identified several issues during his initial review in **March 2020**, one being that he wanted to move home, he was advised that he should contact RBH regarding this matter. He also advised that he was currently in arrears with this rent and was advised to try to clear the arrears as this might be hindering his rehousing application. Adult I also stated he was not sure if he was receiving the correct benefits and so a referral to the Community Connectors was completed.

6.3.4 Due to his mobility problems, he was referred appropriately to the falls team. He was also struggling with taking his medication correctly and managing his insulin. It was agreed that a request for support from the District Nurses (DN) would be made as well as having his medication dispensed in blister packs.

6.3.5 Supportive equipment required in Adult I's home to help his independence was identified as being a perching stool to allow him to sit when cooking, a toilet seat raise and grab rails in his bathroom. As he was struggling with several tasks of daily living a referral to STARS[11] was made to support him with tasks for a period of up to 6 weeks.

6.3.6 The day after STARS staff commenced their support of Adult I they reported mice at the property to ASC. 2 days later ASC were advised that Adult I was not engaging with any tasks on his support plan. He was contacted by ASC staff and encouraged to engage with the support being offered. Having a female support worker was making it difficult to get Adult I to accept help even when she offered to stand outside the bathroom while he washed himself in private. The STARS worker reported that she felt Adult I was not washing himself and that he had refused to let her check pressure areas. After 9 days Adult I cancelled the STARS service and ASC closed his case within the month.

6.3.7 In **July 2020** Adult I contacted ASC again, he was allocated a support planner and in August a further needs assessment was carried out remotely. Similar issues were reported by Adult I, housing, mental health, support with shopping, cleaning, and laundry. He stated his mobility was very poor, he fell often and could not shower independently. He had not had a shower for over a year and stated he was very embarrassed by his incontinence. He had no clean clothes to wear and was hosing down soiled clothing in his shower. He explained that his blood sugars were either too high or too low which was resulting in 'confusion' and that he had a 3 hour round trip to get his insulin from the clinic on public transport which he found exhausting. This was a missed opportunity to convene an MDT meeting.

6.3.8 As a result of this assessment a referral was made to the DN's for a home visit and a continence assessment. The earlier referral to the falls team was to be followed up and Adult I was advised again to contact RBH in relation to his housing issues. It was agreed that a further support package would be put in place with a request for male support workers if possible. The support

[11] Short Term Assessment and Reablement Service

package was commissioned from Cherish UK who supported Adult I from **August 2020** until **November 2020.**

6.3.9 In **August 2020** it was reported to ASC that Adult I was again declining to engage with his support package, that he had an infestation of mice in his property that were having a significant impact on his mental health and wellbeing, as well as a lack of pads to manage his incontinence. Adult I was also reported to refuse medication at times stating he felt it made him 'lazy'. Although the care package had only been in place for I week and reported trust was still building this was a missed opportunity to convene An MDT meeting.

6.3.10 In **November 2020** Adult I contacted ASC to request the cancellation of his care package because he stated he could not afford it. It was confirmed by the support worker that Adult I was not allowing them to assist with his personal care. There were references to whether Adult I had the mental capacity to understand the risks of not engaging with staff, but this was not taken any further, no formal capacity assessment was undertaken or documented. It was clarified with the GP whether a referral for mental health had been completed, ASC were assured that a referral was completed for the access and crisis team. This was another missed opportunity to convene an MDT meeting.

6.3.11 Following further disclosure by Adult I to the duty worker in **January 2021** that he felt his physical and mental health state were poor and that he was still losing weight despite supplemental drinks as well as still having diarrhoea he agreed that his GP could be contacted to share this information. This was another missed opportunity to convene an MDT meeting.

6.3.12 The 3rd needs assessment was carried out in **May 2021** following a telephone call from Adult I who stated that 'he felt very unwell, had lost lots of weight, had nobody to do his shopping or cooking and that the was too weak to do this for himself'. He also informed them that he was struggling to get face to face appointments with his GP

6.3.13 Following the face to face assessment of Adult I's needs in **June 2021** when Adult I also discussed his ongoing low mood, finances, client contribution, mice and cannabis use it was agreed that a further support package would be provided to support him with meal preparation, medication prompts, shopping and personal care. Homecare For You were commissioned and provided support to Adult I from **June 2021** until **February 2022** when Adult I died.

6.3.14 Thinking Ahead received a self-referral from Adult I in **February 2020**, the referral followed the appropriate triage, and he was initially assessed the following month. This assessment was carried out remotely by a PWP. It considered the answers that Adult I gave to a number of questions including his thoughts and behaviours, current medication including substance use i.e. drugs and alcohol as well as the risk of harm to himself including suicidal thought and thoughts of harming others. The outcome of the risk assessment was amber because Adult I disclosed that he had previously tried to hang himself 2 years ago. He confirmed that he had no current plans, believed that things would get better and that he could keep himself safe.

6.3.15 It was agreed with Adult I that his treatment plan would be provided on a 1:1 basis over the telephone by the PWP. This plan was reviewed appropriately within the agency's guidelines

by a senior PWP. Throughout his therapeutic treatment Adult I was seen in accordance with his treatment plan and as per pathway.

6.3.16 When the DN saw Adult I in his home in **October 2020** to assess his needs it was documented that Adult I had mental capacity at that time to give his informed consent to receive treatment to his foot wound. An assessment of his environment noted the previous reports of mice at the property and that Adult I did not like going out because he felt 'people were after him'. It was noted that he had a high risk of falls and had input from the physiotherapy team. This was another missed opportunity to convene an MDT team meeting.

6.3.17 RBH conducted a welfare check in **May 2020** due to concerns being raised about Adult I's welfare. It was noted that Adult I was suffering with his mental health, he confirmed his GP was supporting him but that he was struggling with food and was falling over. It was noted that RBC and RBH had provided 3 food packages to Adult I. Contact was made with the sudden resource centre and ASC who advised that Adult I had not engaged. The Social Worker advised RBH staff that they would 'pick this up with management and call the housing officer if needed'. This was another missed opportunity to convene an MDT team meeting.

6.4 Communication factors (verbal/nonverbal/management)

6.4.1 It is evident that there was frequent communication between agencies involved in supporting Adult I. Much of this was undertaken over the telephone, some of which can be attributed to the Covid 19 restrictions at the time.

6.4.2 In **March 2020** the referral made to the falls team by ASC does not appear on the system at NCA, the only referral within the timeframe of the review is recorded as being from the community matron in **December 2020.**

6.4.3 Following a telephone appointment with his PWP in **November 2020** to start work on schedule planning and setting routine activities Adult I stated he was too ill to do this work because he was vomiting 'acid'. He felt he wanted his GP appointment bringing forward but that his doctor 'was insisting that he was not being reviewed until the 16th when he had a booked appointment' despite Cherish UK and ASC requesting and earlier appointment for him. He felt his doctor 'was not listening'. It was also evident that Adult I felt unsupported by ASC stating, 'no-one from Adult Care is coming to see him, says they ring every 5 weeks'. He was happy with the support from Cherish UK currently. The PWP gained consent from Adult I to contact all services to make them aware of his views.

6.4.4 A Getting Help worker from Thinking Ahead attempted to contact Adult I to offer practical support on 2 occasions in **June** and early **July 2020** but on both occasions there was no reply to telephone messages left.

6.4.5 Letters were sent to Adult I's GP, ASC and Cherish UK by the PWP in **November 2020**. All letters requested that feedback be provided to the PWP so that they could support and assist Adult I to the best of their ability. Agencies did act on these letters however no feedback was received by either the PWP or Adult I himself. Before the end of the month Adult I had been closed to

ASC when he cancelled his care package, had been discharged from the Thinking Ahead Therapeutic pathway and passed to the Getting Help pathway.

6.4.6 A letter to Thinking Ahead was received from Adult I's GP 5 days later in **November 2020** asking them to assess him and work with Adult I. As Adult I was already accessing treatment a service manager at Thinking Ahead was asked to review the records of Adult I and discuss with his existing PWP. As a result, the PWP was advised to ask for a response to the earlier letters from each of the agencies that had been written to and to respond back to the GP's referral letter.

6.4.7 In **November 2020** the PWP rang ASC who advised him that Adult I had cancelled his care package stating that he could not afford it. He reported that he was in receipt of personal independence payments now at the standard rate but not at the higher rate because he didn't want to tell them about the extent of his problems. He requested the PWP's support to see if there were any other benefits other than job seeker allowance which he received that he could access. He stated he felt the process was 'overwhelming without support', this was not the role of the PWP as they do not have this specialised knowledge. Adult I felt that other than support with his benefits he didn't require any additional guided self-help therapy the PWP engaged him with.

6.4.8 A further risk review was carried out by the PWP on the same date, there were no new risks disclosed. Adult I was still experiencing the same suicidal thoughts as before but there was no increase in frequency or intent, and no plans to act on them. As no further support was required Adult I was discharged from the therapeutic services part of the Thinking Ahead pathway and was handed to the Getting Help part of the pathway to support him with support applying for benefits.

6.4.9 There was good communication by Cherish UK staff in reporting the continued difficulties in getting the mice infestation dealt with on behalf of Adult I. This was eventually resolved when Adult I agreed to pay for the service but could not pay by debit card because he only had access to his money in a Post Office account. Cherish UK staff were also in contact with the DN's to try and obtain incontinence pads for Adult I. In **September 2020** when carers could not access Adult I's property because he had had a seizure, they contacted the appropriate agencies for support. They also followed up the outcome of the out of hours GP visit in **October 2020** following them reporting their concerns that Adult I wasn't taking his medication correctly and was 'doubling up' on them when he had forgotten to take them.

6.4.10 The PWP communicated well with ASC, GP and Care Provider in requesting information from them to enable them to understand Adult I in a holistic manner to allow them to offer the best support to him. Care plans were requested but never shared with the PWP. The PWP was the only practitioner that discussed their work with Adult I with a senior manager to gain support and advice in relation to any further actions that could be taken to support Adult I.

6.4.11 Following a GP telephone review in **September 2020** Adult I told the GP that he still had multiple problems, he was taking the antidepressants but didn't feel they were having any positive benefit. He was still experiencing abdominal pain with intermittent vomiting. He also stated that he was developing a fear of needles and as a result he was eating less to reduce the amount of insulin he was needing to take. A plan was agreed with Adult I which included the

GP speaking to one of the brothers that lived in Rochdale to see if he could support Adult I. This contact was made, the brother agreed to try and support, as far as his own health issues allowed him to. This was a missed opportunity to convene an MDT meeting.

6.4.12 In **October 2020** Adult I had a face-to-face appointment with his GP, the mouse infestation was discussed, and the GP requested the name of the Social Worker who was supporting Adult I. It was also noted that Adult I had not attended hospital for his leg scan, a re-referral was made and a referral to the DN service for incontinence pads. There was further contact between the podiatrist and the GP the same month following their visit. It was reported that there was evidence of infection in the foot that was tracking up the leg and swelling in the groin. The GP rang Adult I and expressed the concern about sepsis. Options for assessment were given with Adult I agreeing to go to the Urgent Care Centre (UCC).

6.4.13 The GP was contacted by Adult I's care worker in the same month who informed the GP that Adult I was not taking his medication as directed but was over medicating and having sickness and diarrhoea, his leg was also much more swollen than before despite the antibiotics given to him at the UCC. Adult I agreed to attend hospital on this occasion. This was a missed opportunity to convene an MDT meeting.

6.4.14 In early **November 2020** Adult I contacted the GP surgery to inform them that he had collapsed the previous night and hit his head on the door. He had been dizzy most of the previous day because he hadn't eaten or drunk anything and was too weak to attend surgery. He was advised not to take insulin if he wasn't eating and the need for a home visit. Mental Health and self-neglect were noted at this consultation, but no further action was taken as a result. The following day the duty worker at ASC contacted the GP about the concerns relating to Adult I's health, they were advised that the practice could not undertake a home visit as they did not have the resources for a thorough check on Adult I. The duty worker was signposted to the 7-day access service, when contacted this service stated they only took referrals from GP's. This was another missed opportunity to convene an MDT meeting.

6.4.15 Later the same month Adult I had a telephone review with his GP, again he reported ongoing diarrhoea and sporadic vomiting for several months, also feeling dizzy and weak on standing. He reported staying in most of the time but becoming more aggressive when going out. He was having to rely on taxis to get to appointments. He was engaging with Thinking Ahead but that this wasn't really helping, no suicidal thoughts were expressed. The GP referred Adult I for tests and to the mental health access and crisis team. The following day ASC contacted the GP following Adult I's request to cancel his carers. It was confirmed with the GP that a referral to mental health was made. This was again another missed opportunity to convene an MDT meeting.

6.4.16 Two further GP contacts were made in late 2020 the same issues were noted, Adult I was added to the practice monthly meetings to discuss with the community matron in **November** and weight loss of 14% noted from February was noted in **December 2020**.

6.4.17 There was good communication between the community dietician, Adult I and his GP in **February 2021.** A comprehensive care plan was discussed with Adult I and followed up in writing which was also shared with the GP. Concerns were raised at this time in relation to weight

loss. The GP was advised to change his supplemental drinks to a high carbohydrate version and to titrate his insulin dose accordingly.

6.5 Resource factors (availability, useability)

6.5.1 It was identified early in 2020 that Adult I was suffering from double incontinence. Referral into this service is non-urgent and Adult I was seen within the expected timeframe. An initial assessment of Adult I's needs was made, and a urinal bottle provided at the first visit. Establishing the appropriate continence aids and supplies is based on an individual's needs. Adult I did not feel any of the products available to him on the NHS would be ones he wished to use, as a result he was signposted by the continence nurse to suppliers who might be able to provide him with products he felt would be appropriate.

6.5.2 It was identified that Adult I would benefit from having a bath board to allow him to shower more safely. There appeared to be a delay of 3 months in obtaining this piece of equipment the reasons for which are unclear. Given that Adult I struggled so much with meeting his hygiene needs and had cancelled his care package this was a very unfortunate delay.

6.5.3 When Adult I had a seizure in his home in **September 2020** carers could not initially access to him as he was unable to answer the door. A key safe was recommended however Adult I declined due to the cost; a client care line was also offered however this too was declined by Adult I due to cost.

6.5.4 In engaging with Adult I peer support was not explored, it is unclear whether there are peer support networks in Rochdale that could befriend people of Muslim faith who need assistance in attending appointments or are willing to visit people of the same faith to alleviate loneliness. **[Recommendation 5]**

6.6 Working conditions (environment, staffing, Covid 19 restrictions)

6.6.1 Covid 19 restrictions had a significant impact on Adult I's mental and physical health. When the highest levels of government restrictions were in place ASC and GP's moved to remote working practices and face to face contact with clients/patients was kept to an absolute minimum to protect people as well as essential workers. Adult I also had very limited contact with family and his few friends during this time.

6.6.2 As restrictions were eased by the government Adult I was seen in his own home by staff including most frequently by DNs, GP, RBH staff and his carers. Adult I complained of feeling neglected and abandoned by services during the timeframe of this review, his poor mental health would have been a significant contributory factor to his feelings because he was already suffering from anxiety and depression.

6.6.3 The Covid 19 pandemic placed additional pressures on the care sector both across health and social care with staff having to isolate if they tested positive for Covid. In 2021 the Home Care Association (Home Care Association, 2021) Published the results of their third survey from November following earlier reports in July and August 2021 on the shortage of homecare workers. The aim was to test whether the situation had changed substantially since their last survey

in August 2021. Their findings suggested a deepening crisis in workforce capacity. 98% of care home providers sated that recruitment was harder than before the pandemic. The CQC's annual reports on the state of care in 2020/21 and 2021/22 also highlighted the pressures on the health and care system because of the pandemic.

6.6.4 Although Adult I's home environment was contaminated by mice this did not impede staff going into his home to deliver his care when access was granted by Adult I. There were occasions when Adult I appeared not to be at home in **July 2020** when staff were expecting to visit him.

6.7 Organisational factors (structure, safety culture)

6.7.1 Each agency involved in providing staff to support Adult I have clear management structures and escalation routes. The use of multi-disciplinary team meetings this is less clear. Most individual agencies have their own multi-disciplinary team meeting structures for example the DN team have 'huddles' at which external agencies outside health such as support planners and social workers from ASC are invited to. The GP surgery staff hold QIPP meetings[12], Adult I was discussed at a practice meeting and as a result the community matron and social prescriber were asked to support Adult I.

6.8 Education and training (Competence, supervision)

6.8.1 All agencies who have participated in this review have provided assurance that staff have received adult safeguarding training that includes the definition of self-neglect as described in the Care Act 2014[13] . In respect of the RBSAB policy and procedures all agencies have policies and procedures accessible to staff that are aligned to the RBSAB policy and procedures. In most agencies these include a 7-minute briefing on self-neglect and the Multi Agency Risk Management Protocol (MRM).

6.8.2 Over recent years training on the use of the MRM has taken place extensively across the borough following its introduction in 2015 and following recommendations from previous SAR reports commissioned by RBSAB in self-neglect cases. The practitioners who attended the Learning Event in November 2022 confirmed that they were aware of both the definition of self-neglect in their safeguarding policies, and most were aware of the MRM protocol.

6.8.3 The reasons why none of the staff had felt it necessary to refer Adult I into safeguarding procedures was explored at the Learning Event. The PWP felt they had raised safeguarding concerns about Adult I when they wrote the letters to ASC, the GP and the care provider. ASC are the lead agency for safeguarding procedures to be instigated because no formal safeguarding referral was received by ASC from Thinking Ahead these procedures were not acted upon. The GP felt that because they were aware of the number of agencies that were supporting Adult I a safeguarding referral 'would add nothing new' as the lead agency were already aware of the concerns about Adult I. The PWP was the only practitioner not to see Adult I in person in his home environment as all engagement was delivered remotely. They were acting on the self-reports of Adult I and believed in good faith that in writing the letters they had referred into safeguarding procedures.

[12] Quality, innovation, productivity, and prevention
[13] Self-neglect at a glance: what is self-neglect

6.8.4 Staff agreed that self-neglect was clearer to work with when you could evidence that the person who was self-neglecting lacked the mental capacity to make an informed decision. They were very clear that in this situation you would refer into adult safeguarding following a mental capacity assessment and best interest decision. Thinking ahead staff are not trained in conducting mental capacity assessments, expecting that ASC would undertake this assessment once information had been shared with them.

6.8.5 As other SARs on the national database have found when the person appears to have the mental capacity to make an 'unwise' decision this is a greyer area of practice. The practitioners were very aware of the 'making safeguarding personal' agenda and of a person's 'right to autonomy' and their rights under the Human Rights Act 1998[14]. They expressed a view that their adult safeguarding training refers to legal literacy in this context but not in a great deal of depth. When asked if they would find it helpful to have access to further training on legal aspects of safeguarding including the role of the courts in relation to inherent court of protection cases and to complex self-neglect cases where there were repeated examples of a person's refusal to engage in supportive measures to promote their health and wellbeing this was felt to be a positive proposal. **[Recommendation 1]**

6.8.6 The PWP from Thinking Ahead met with a case management supervisor in **March 2020** to review the information gathered at the wellbeing assessment of Adult I and agreed with the outcome that step 2 guided self-help was indicated as an appropriate treatment based on Adult I experiencing low mood and anxiety and the lack of immediate risk. They also discussed Adult I in case management supervision in **December 2020** when it was agreed that the PWP would make a referral to getting help for benefit advice/support and would update Adult I's GP.

6.9 Team and Social factors (role congruence, leadership)

6.9.1 There was consensus amongst the practitioners working with Adult I that he had care and support needs and that they had a duty to act to support his health and wellbeing. No agency took a leadership role in bringing multi-agency staff together to discuss all the aspects of Adult I's care needs. This led to agencies acting either in isolation or with other teams within their own service (health). Having a RBSAB multi-disciplinary meeting guidance document that all partner agencies agree to, and follow would assist risk assessment and management when adult safeguarding thresholds are not felt to have been met. **[Recommendation 1]**

6.9.2 In **May 2020** it is not clear from the conversation that the RBH staff had with the social worker about Adult I's mental health and home situation was 'shared with management' and if it was what the outcome was. There were also missed opportunities for ASC to assess Adult I's mental capacity and to convene a multi-disciplinary team meeting each time Adult I cancelled his care package. This would have been an opportunity for other agencies to know that homecare support was no longer in place. **[Recommendation 1]**

[14] Human Rights Act 1998: Article 2 the right to life, Article 3 the right to freedom from inhuman or degrading treatment, Article 5 the right to liberty and security and Article 8 the right to a private and family life

6.9.3 Each agency has a safeguarding lead who can offer support to staff who are working with complex cases. Staff also have access to supervision from managers within their own organisations. The frequency of this differs between agencies but all will support staff who wish to discuss a case they are working with that concerns them as a matter of urgency if required. This escalation was only triggered by the PWP who took their concerns to a case management meeting and was advised to follow up on the letters sent, but not responded directly to by ASC, GP and Care Provider.

6.9.4 The PWP emailed the duty team in **September 2020** for guidance after his contact with Adult I the day before. The duty team advised the PWP to contact Adult I again to establish what psychological needs he had that could be met within Thinking Ahead and was not intended to obtain a holistic overview of all his needs.

6.9.5 None of the practitioners at the Learning Event expressed that they felt out of their depth or unsupported in their management of Adult I.

7. Good Practice

Single Agency Learning

7.1 Rochdale Borough Council Adult Social Care

7.1.1 An additional social work team manager is being appointed to support with risk management and case escalation.

7.1.2 A group session has been held focusing on self-neglect cases including legal requirements and guidance, resources/protection plan options available and emphasis on adopting a multi-disciplinary approach.

7.1.3 A group session has also been held focusing on local authority safeguarding responsibilities giving an overview of legislative requirements, guidance, and practical advice on how to apply and how to evidence decision making within own practice.

7.1.4 Rochdale's Safeguarding Board Learning Brief focusing on adult self-neglect and engaging family and friends has been circulated to all teams.

7.1.5 A review of the local authority training requirements has been completed and all staff teams booked onto in house formal Safeguarding Enquiry Practitioner Training and Responding to a Safeguarding Concern Training.

7.1.6 A group session has been held on the role of the Coroners Court including some case reviews of previous cases where enquiries were held regarding self-neglect cases.

7.2 Northern Care Alliance NHS

7.2.1 Following the delay in the supply of incontinence pads to Adult I this has been reviewed by NCA and there is a drive towards engaging with home care providers to take ownership of making the right contacts to ensure products are delivered in a timelier manner.

7.2.2 Supporting staff to embed MCA training as a core part of the work they do and to increase their confidence in the valuable support the MCA can provide when delivering clinical care.

7.3 Thinking Ahead

7.3.1 This provider was not aware of the MRM protocol within RBSAB safeguarding procedures at the time they were engaged with Adult I. They have now received a briefing video and safe-guarding leads in the organisation will be reviewing this. The position for the group will be to make staff aware of the protocol and how to refer, flag, request, and support an MRM.

8. Conclusions

8.1 Adult I

8.1.1 Adult I was a gentleman in need of care and support. Due to his ongoing physical and mental health issues, he found it difficult to engage with all support that was being offered to him at various times over the timeframe of this review, some of which he felt was not addressing his concerns.

8.1.2 There is no evidence to suggest that Adult I was ever asked if he wished to receive a direct payment and employ a personal assistant to support him in meeting his care needs which should be the default position of ASC. Existing mechanisms are in place to ensure that default cash budgets remain the first offer of support to people as it currently requires an integrated health and social care lead approval.

8.1.3 Adult I was offered support with his mental health issues and engaged well with the PWP however Adult I declined psychological input aimed at addressing anxiety, depression and suicidal thoughts. As such the contact that the PWP had with him was focussing on alerting other agencies to his living conditions, his care needs and his physical health problems. Once this information had been shared and followed up on with the agencies in question Adult I told the PWP that he did not want psychological support but wanted to prioritise support around benefits and other care needs.

8.1.4 Staff did report signs of him self-harming by burning his arms with cigarettes as he had done in the past as a coping strategy. His feelings of hopelessness over his housing situation and the recurring mouse infestation at the property for prolonged periods can be seen to have played a contributory factor.

8.1.5 Adult I was supported by his GP to manage his physical and mental health problems, no mental capacity assessment was felt necessary, and he was referred appropriately to secondary care, mental health and substance misuse services as well as the DN, Diabetes Team, and Dietician.

His view of his support from his GP was impacted by the Covid 19 pandemic and the amount of telephone reviews he was having. He described feeling not listened to and not having medication reviews as often as required as well as having requests to bring forward appointments ignored.

8.1.6 When offered additional support from ASC he accepted and then struggled to engage with aspects of his care plan. He cited embarrassment at having female carers to support him with washing, as well as the short visits feeling 'rushed' and for some of which he was not at home for.

8.1.7 For periods of 2020/21 there was a reliance on telephone contact with Adult I, he stated that he didn't always respond to private numbers because he was being targeted by bad people. Messages were left for Adult I when he consented to this, it is unclear why he did not consent to this with Thinking Ahead staff when he lived alone in his property.

8.1.8 His feelings of loneliness exacerbated during the pandemic; he was offered community engagement support but again declined the offers.

8.2 Staff factors

8.2.1 The staff involved in supporting Adult I all acknowledged that he had care and support needs, and considered what appropriate support their agency was able to provide for Adult I. When risks were not receding or indeed increasing there is evidence to confirm that staff regularly considered what additional support could be offered to Adult I to meet his needs and who was best placed to be able to provide this. Multi-agency meetings would have supported this work and enabled clear risk management actions with lead agency and timeframes for completion. **[Recommendation 1]**

8.2.2 Due to the numbers of agencies already aware of and attempting to support Adult I, it could be concluded that staff felt that an adult safeguarding referral would not 'add anything new' to the work already in place to support Adult I or that the threshold had not been met because Adult I had the mental capacity to make an informed decision. This is supported by the lack of comments at the Practitioner Learning Event over the combined chronology. Only the District Nurse representative stated that they were not aware that Thinking Ahead were supporting Adult I.

8.2.3 Where staff did have concerns, these were discussed in mostly single agency groups such as 'Health'. There was no consideration given to escalating to their internal safeguarding leads for support and advice over initiating an MDT meeting or the safeguarding process.

8.2.4 ASC identified that much of the case work was done reactively by staff on duty. When it is clear that cases are increasing in complexity due to multiple needs the allocated professional should retain responsibility for case management. In **October 2020** when the duty team became aware Adult I was not taking his medication correctly the action was to try and contact the DN to discuss rather than call and MDT and reallocate to a social worker. In **November 2020** when Adult I had a seizure and carers could not gain access to his property, Police and

NWAS were called to attend, this first instance of no access should have triggered consideration for an MDT meeting.

8.2.5 In **November 2020** when the PWP wrote to ASC to share information about Adult I this was again another missed opportunity to convene an MDT meeting. The cancellation of the care package by Adult I should also have led to consideration of the safeguarding process.

8.2.6 There was also evidence that staff did not apply Care Act eligibility criteria, it would therefore be beneficial for staff to have a refresher update on applying the Care Act eligibility criteria

8.2.7 In **May 2021** following the contact Adult I had with ASC reporting that he had lost lots of weight, couldn't get a face-face appointment with his GP, and was too weak to cook and shop for himself this was allocated to a support planner. The allocated worker was on leave for a period, an attempt was made to contact Adult I back 2 weeks later, and again 2 weeks later when a visit was scheduled. Given the case history the initial call should have been given to a social worker and an MDT meeting planned.

8.2.8 Adult I was able to engage in discussions about his care and what he wanted outcomes to be. Had any agency discussed a safeguarding referral with him which would allow agencies to be bought together to share information and put together an assessment of risks and a safety plan to support him on the balance of probability it is likely that he would have consented to this as he consented to let the PWP write to his GP, ASC and Cherish to request their care plans for Adult I so that the PWP could obtain a holistic view of the support currently in place for him.

8.2.9 The PWP did not physically see Adult I and did not actually have the opportunity to work with him within the boundary of the PWP's work. The focus of the support offered by the PWP was managing care needs, not providing psychological input, and by the time that information had been shared and responded to, Adult I reported that he no longer wanted to address his mental health and wanted to focus on other care support such as help with benefits. The PWP took great care not to simply discharge Adult I at the beginning of his time with the service.

8.2.10 The ASC worker who was managing Adult I's care at some points was managed by the central adult care team but was supported by the West DN team. If he had been under the central DN Team, there would likely have been better communication as they are based in the same office. In **August 2021** when RBH notified ASC of the evidence of burns to Adult I as a result of self-harm this was again another missed opportunity to convene an MDT or consider the safeguarding process. The duty team also managed the call from the care provider reporting Adult I was refusing to eat and was fixated on moving leading to depression. As the allocated worker had left the service the case should have been reallocated to an alternative worker for oversight.

8.2.11 In late **September 2021** there was a 20-day delay in ASC discussing with Adult I taking his medication following notification by his carers. This was picked up by the duty team leading to a delay in allocating the task to review. During this time a daily care package was in place and the delay does not appear on this occasion to have resulted in any harm to Adult I. In

November 2021 there was again a missed opportunity to convene an MDT meeting when the carers reported to ASC that Adult I was having suicidal thoughts.

8.3 Task factors

8.3.1 There were clear policies and procedures for adult safeguarding across the RBSAB partners which included MRM and a focus on self-neglect in the 7-minute briefing guide.

8.3.2 The current MRM protocol links the triggering of a multi-disciplinary risk management meeting to the safeguarding policy at the top of page 7 it reads *The MRM protocol can be used where there is documented evidence that an adult refuses to engage with the s42 safeguarding process, and where evidence suggests they are at risk of serious harm or death.* This suggests that the MRM may not be used unless the safeguarding process has been started and the person is not co-operating.

8.3.3 Balancing autonomy and duty of care remains a prominent theme in safeguarding adult reviews[15]. Multi-agency meetings are critical to discuss difference of opinion between professionals, use adult safeguarding principles, evaluate preventative or risk mitigation options. **[Recommendation1]**

8.3.4 All agencies should review their safeguarding training to ensure that staff are clear that when they safeguarding threshold is met they make a safeguarding referral and when they are sharing information that does not meet the safeguarding threshold they are clear with the receiver that this is just an information exchange. **[Recommendation 3]**

8.3.5 The continence nurse saw Adult I within the expected timeframe for assessment following referal, the first visit being at the beginning of **September 2020**. The assessment included the provision of a urinal in the first instance and information and examples of different incontinence pads based on Adult I's needs. The records indicate that there was not a product available that Adult I felt would meet his requirements. In such cases signposting advice is and was given in relation to where he could obtain other products.

8.4 Communication factors

8.4.1 Agencies did communicate with each other frequently when sharing information about Adult I. Some of this was via e-mail and some via telephone conversations, there was little face to face contact between agencies. Where this was not effective or as prompt as it could have been this was in part due to the agency best placed to manage the concern was not contacted directly see 8.4.6 below, it also led to repeated referrals, (falls team, community connectors).

8.4.2 DN's have a daily safety huddle meeting which was in place during the timeframe of this review and Social Workers usually attends these meetings where concerns around care provision, risk and potential safeguarding issues are highlighted. There is no documented evidence to provide assurance that appropriate information was shared at these meetings. A learning point

[15] Self-Neglect and Safeguarding Adult Reviews: Towards a Model of Understanding Facilitators and Barriers to Best Practice

for NCA because of this review has been put in place to ensure that in future huddle meetings, information shared and actions as a result are securely documented and stored.

8.4.3 Written letters by the PWP to different agencies prompted action but did not result in the requested feedback to either the PWP or Adult I in **September** and **November 2020.**

8.4.4 The DN service communicated well with other health professionals liaising with podiatry and the Tissue Viability Nurse (TVN). Poor diabetic control was noted and an urgent referral to the diabetic team was made. They also alerted ASC to their concerns that Adult I's home was contaminated with mouse droppings. This was a missed opportunity to convene an MDT meeting.

8.4.5 The 2nd Care Provider who supported Adult I from **June 2021** to **February 2022** stated that Adult I was independent enough to contact his own GP without their support when he was not feeling well. They felt they had little need to discuss Adult I with ASC as from their perspective there were no major issues with supporting Adult I. This is in contrast to a conversation they had with ASC in August 2021 when they reported that Adult I was stated as showing staff burns he had caused to his arms himself because he was not happy with how things were and he wanted RBH to see the condition of his property.

8.4.6 The Care Provider had no communication with the DN service over Adult I when they were attending to check his pressure areas, the management of these did not require their input. Over the time frame of their involvement with Adult I they felt his sense of wellbeing had improved latterly, he had refurbished his property buying new kitchen appliances, a new bed and sofas.

8.4.7 RBH staff escalated their concerns to ASC in **November 2021** when Adult I disclosed to them that he was having suicidal thoughts. Contact was made with Adult I the same day by ASC and they advised RBH to contact Adult I's GP to report their concerns.

8.5 Resource factors

8.5.1 The number of teams across the system available to practitioners to refer to in assisting people with care and support needs is something the author believes the RBSAB should be proud of in the current economic climate. Across the health and social care system there were many of these workers supporting Adult I. From Social Care he was referred to the Community Connectors and Motiv8, in health the Community Matron, Social Prescriber and the Focussed Care Worker are evidenced.

8.5.2 Had any MDT meetings been arranged co-ordination of all these different support staff could have been planned for different times when it was appropriate for them to offer support. Adult I appears to have welcomed any support with activities of daily living and support with benefit applications despite the confusion in his head. Agencies would then be clearer on who Adult I had been referred to and who was currently working with him. **[Recommendation 1]**

8.6 Working conditions

8.6.1 Despite the initial difficulties at the beginning of the Covid 19 pandemic agencies did recommence face to face visits when government restrictions allowed this. Adult I was seen by a Social Worker on 2 occasions in his own home prior to the first lockdown in **March 2020**.

8.6.2 Over the timeframe of this review there is no evidence to support that staffing levels were compromised or had an adverse effect on the care Adult I received. When he complained about rushed visits by care staff this is a common problem nationally which existed pre pandemic and is a result of how the 'system operates'.

8.7 Organisational factors

8.7.1 There are clear structures set out in each organisation identifying how concerns can be raised via internal escalation and what options are available if the concern is not felt to be addressed appropriately.

8.7.2 In addressing the needs of Adult I there is no evidence to support an overly paternalistic view on how Adult I should have his needs met. He was given choice and control where this was possible and staff did their best to support him with achieving the outcomes he desired.

8.8 Education and Training factors

8.8.1 At the Practitioner Learning Event some staff acknowledged their training on and awareness of the MRM protocol. Thinking Ahead staff were not aware of MRM protocol within RBSAB safeguarding procedures. They have now received a briefing video and Safeguarding Leads in the organisation will be reviewing this. The position for the group will be to make staff aware of the protocol and of how to refer, flag, request, and support an MRM given that staff and services are not qualified or in a position to assess capacity.

8.8.2 Some agencies who worked with Adult I undertake Health Education England[16] Level 3 safeguarding adult training which is generic and does not include local additions to practice such as the MRM process in Rochdale. **[Recommendation 2]**

8.8.3 Despite most partner agencies push on this training in recent years there remains a disconnect between 'knowledge' and 'practice' across Rochdale as evidenced in more recent SAR reports commissioned by the RBSAB. **[Recommendation 2]**

8.8.4 The challenge for agencies is how do they support their staff in making this connection. Writing in the Journal of Adult Protection Michael Preston-Shoot picks up the theme that learning being missed is twofold. Investing in training will prove ineffective without also focussing on workplace development to ensure that staff can embed in practice acquired knowledge and skills[17]. Is supervision available to staff of a good quality and valued by them, where group supervision would be beneficial do agencies provide this or have the capacity to do so to spread learning if a complex case is appropriate for sharing?

[16] E learning for healthcare
[17] On (not) learning from self-neglect safeguarding adult reviews

8.8.5 Practitioners attending the Learning Event felt they would be strongly in favour of a learning event hosted by the RBSAB focussing on cases such as Adult I and others who have capacity but who make unwise decisions and in whom risk is escalating. Support in a better understanding of executive function would be appreciated. **[Recommendation 4]**

8.9 Team and Social factors

8.9.1 There was no disagreement between staff that Adult I did have care and support needs that meant they had a duty of care towards him.

8.9.2 Teams appeared to work satisfactorily within agencies, the difficulties came in bringing different teams together to share knowledge and concerns for Adult I. Despite practitioners having the necessary knowledge and experience to undertake their roles in supporting Adult I there was no escalation or leadership demonstrated in actioning any multi-disciplinary work. The introduction of RBSAB multi-disciplinary team meeting guidance used across all partner agencies would assist in supporting staff to understand this process and know where in their own agency to discuss initiating the process. **[Recommendation 1]**

9. Recommendations

The recommendations have taken account of the changes to practice that the panel members identified from their own organisations as well as considering changes across the system

Recommendation 1
• The RBSAB works with its partner agencies to agree multi-disciplinary team meeting guidance that provides clear indicators for when an MDT meeting **should** be considered and the process for such meetings to happen. • The guidance must be clear that an MDT meeting is **best practice** in response to a person's increasing vulnerability and/or increasing risk to their health and wellbeing **when the safeguarding threshold has not been met.**
Recommendation 2
• RBSAB seek assurance that all agencies ensure that their adult safeguarding training incorporates the Multiagency Risk Management (MRM) process and how this should be instigated when someone in safeguarding procedures is not engaging with the safeguarding process. • The MRM should be seen as a trigger for escalation across agencies when risk is increasing.
Recommendation 3
• RBSAB seek assurance that all agencies use the correct terminology when sharing information. If the communication is purely for the purpose of sharing information

to allow additional support to be considered this should be clear. If the information they are sharing meets the safeguarding threshold this must be stated as such.
Recommendation 4
• The RBSAB considers the request of the practitioners at the Learning Event that further support is provided to practitioners to understand executive function within the Mental Capacity Act. • This could be achieved by holding a learning event that is recorded to share the learning from this SAR with links to legal videos to support better understanding.
Recommendation 5
• The RBSAB should request a review of all resources available to practitioners around support for those in the community who express a wish to seek help to reduce their feelings of loneliness.

10. References

1. Care Act 2014 https://www.gov.uk-government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed August 2022]
2. Ibid
3. 9 protected characteristics in the Equality Act 2010 https://www.equalityhuman-rights.com>equality-act [Accessed August 2022]
4. Ibid
5. Community Connectors – our Rochdale https://www.ourrochdale.org.uk>direc-tory>service [Accessed October 2022]
6. Motiv8:home https://www.motiv8mcr.org [Accessed October 2022]
7. Mental Capacity Act 2005 – The 5 principles https://www.scie.org.uk>directory>bild-poster-PDF [Accessed October 2022]
8. Recruitment and retention in adult social care: a qualitative study July 2022 https://www.gov.uk>publications [accessed October 2022]
9. Care Act 2014: chapter 13 assessment and eligibility https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/determination-eligibility [accessed July 2022]
10. Care Act 2014: chapter 23 direct payments https://www.legisla-tion.gov.uk/ukpga/2014/23/part/1/crossheading/direct-payments/enacted [Ac-cessed July 2022]
11. Short Term Assessment and Re-ablement Service https://www.ourroch-dale.org.uk>rochdale>directory [Accessed July2022]
12. QIPP national workstreams updated – GOV.UK https://www.gov.uk>Healthandsocial-care [Accessed July 2022]
13. Self-neglect: At a glance | SCIE https://www.scie.org.uk>Home>Self-neglect [Ac-cessed July 2022]
14. The Human Rights Act 1998 – GOV.UK https://www.legisla-tion.gov.uk>ukpga>1998>contents [Accessed July 2022]
15. Self-neglect and safeguarding adult reviews M Preston-Shoot 2019 Emerald Insight https://www.emerald.com [Accessed September 2022]
16. elearning for healthcare level 3 course updated March 2020 https://www.e-lfh.org.uk>safeguarding [accessed December 2022]
17. On (not) learning from self-neglect safeguarding adult reviews – by M Preston-Shoot 2021 Emerald Insight https://www.emerald.com [Accessed September 2022]

11. Statement by the Independent Reviewer

The reviewer, Michelle Grant is independent of the case and of Rochdale Borough Safeguarding Adult Board and its partner agencies.

Prior to my involvement with this Safeguarding Adult Review:

I have not been directly concerned with the adult or the carers and professionals involved with the adult, nor have I given any professionals advice on this case at any time.

I have no immediate line management responsibilities for the practitioners involved.

I have appropriate recognised qualifications, knowledge, experience and training to undertake this review.

The review has been conducted appropriately and with rigorous analysis and evaluation of the issues set out in the Terms of Reference.

Independent Reviewer

Signature:

Name: Michelle Grant

Date: 24.02.2023

Appendix 1 Adapted from the National Patient Safety Agency Analysis Toolkit

Patient Factors
Clinical Conditions
Psychological factors

Mental Health difficulties
Diabetes
Chronic pain
Literacy
Financial difficulties

Staff Factors
Personality
Cognitive factors

Lack of curiosity about meaning of behaviour
Failure to escalate

Task Factors
Guidelines/procedures
Decision aids

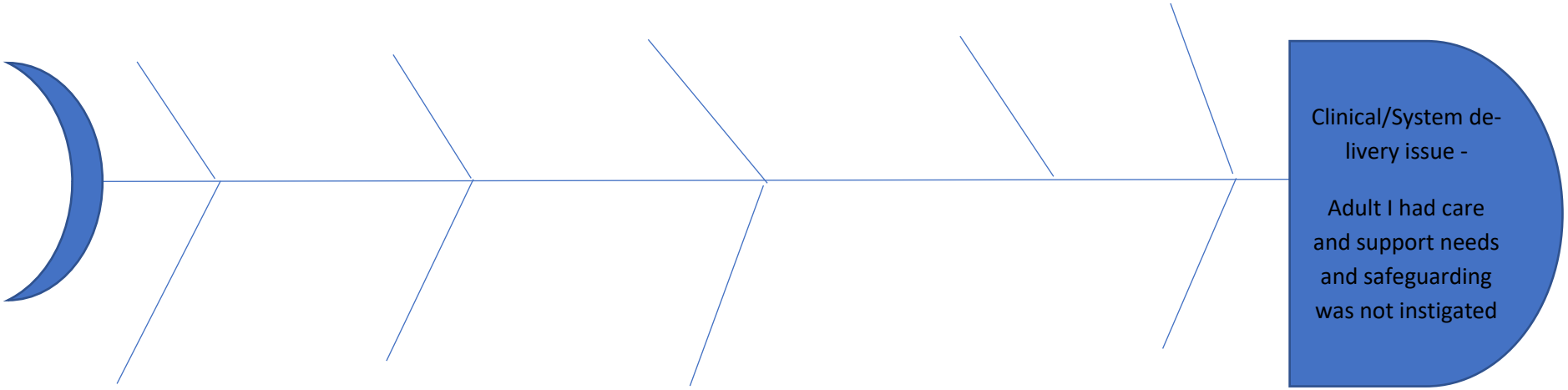
Absence/inadequacy of risk assessments
Legal literacy

Communication Factors
Verbal/non-verbal
Management

Lack of management of escalating risk
Information sharing

Resource Factors
Availability
Useability

Delay in accessing



Working Conditions
Environment
Staffing

Covid 19 restrictions

Organisational Factors
Organisational structure
Safety culture

Management oversight of cases were there is escalating concern
Contract Management

Organisational policy not followed

Education & Training Factors
Competence
Supervision

Safeguarding literacy & confidence of staff with cumulative patterns of behaviour
Ongoing development of staff

Team and Social Factors
Role congruence
Leadership

Understanding of others roles
Poor leadership