

**Thematic Analysis**

**of**

**Safeguarding Adult Reviews**

**Independent Author:** Allison Sandiford

**Contents**

[**1. Introduction and Methodology** 3](#_Toc176785036)

[**2. Core Information:** 4](#_Toc176785037)

[Core information pertaining to the commissioned Safeguarding Adult Reviews 4](#_Toc176785038)

[Core information pertaining to the Screening Referrals 6](#_Toc176785039)

[**3. A Summary of the Findings of the SARs by Theme.** 7](#_Toc176785040)

[**4. Conclusions:** 18](#_Toc176785041)

[A Summary of the Professional Practice and Recognised Developments 18](#_Toc176785042)

[What More Needs to be Done? 20](#_Toc176785043)

[**Appendix A** 28](#_Toc176785044)

[**Appendix B** 28](#_Toc176785045)

[**Addendum to the Thematic Analysis of SARs** 31](#_Toc176785046)

[1. Circumstances Leading to the Addendum 31](#_Toc176785047)

[2. Objectives of the Multi-Agency Audit for Safeguarding Referrals 32](#_Toc176785048)

[3. Methodology 32](#_Toc176785049)

[4. Outcome 32](#_Toc176785050)

# **Introduction and Methodology**

* 1. Rochdale Borough Safeguarding Adult Board commissioned this independent review to analyse a range of Safeguarding Adult Reviews (SARs) screened and/or commissioned by themselves between (and including) 2020 and 2023.
  2. Rochdale Borough Safeguarding Adult Board sought to understand the collective findings which would indicate any outstanding issues to be addressed, in order to support learning from recurring themes.
  3. Allison Sandiford was appointed as lead reviewer. Allison is an independent safeguarding consultant with a legal background, who gained experience in safeguarding whilst working for a police service. Since 2019 Allison has conducted serious case reviews and safeguarding practice reviews in both children’s and adults safeguarding, and domestic homicide reviews. Allison does not have any current links to Rochdale Borough Safeguarding Adults Board, or any of the partner agencies.
  4. Membership of the panel established to oversee this review is shown at Appendix A. The panel met on three occasions to discuss the findings and learning and to monitor the progress of the review.
  5. The following Review reports/Screening Referrals were provided to the independent reviewer:

Screening Referrals

|  |  |
| --- | --- |
| Date of Screening | Reference |
| 03.2021 | Adult 1 |
| 04.2021 | Adult 2 |
| 05.2021 | Adult 3 |
| 09.2021 | Adult 4 |
| 12.2021 | Adult 5 |
| 10.2022 | Adult 6 |
| 03.2023 | Adult 7 |
| 12.2023 | Adult 8 |

Safeguarding Adult Review Overview Reports[[1]](#footnote-1)

|  |  |
| --- | --- |
| Reference | Presented to Rochdale Borough Safeguarding Adult Board |
| Adult D (Lian) | May 2020 |
| Adult E | May 2021 |
| Adult F (Amira)[[2]](#footnote-2) | November 2021 |
| Adult G | March 2022 |
| Adult H (Percy) | February 2023 |
| Adult I | August 2023 |
| Adult K | October 2023 |
| Adult L | October 2023 |

* 1. The independent reviewer read the Screening Papers, the Overview Reports and the Learning Briefs pertaining to each review, before analysis was carried out by summarising the core information and examining the emerging themes and learning outcomes.
  2. Thereafter Rochdale Borough Safeguarding Adult Board was asked to provide detail of any significant changes to practice that have taken place as a result of the above reviews/screenings.

# **Core Information:**

**Core information pertaining to the commissioned Safeguarding Adult Reviews (SARs)**

* 1. Referral Source and Wards of Subject

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Review of | Referral Source | Gender of Subject | Age of Subject[[3]](#footnote-3) | Ethnicity | Ward |
| Adult D | Adult Social Care | Female | 22 | British Pakistani | Rochdale South |
| Adult E | Adult Social Care | Male | 71 | White British | Middleton |
| Adult F | Pennine Care Foundation Trust | Female | 24 | British Pakistani | Rochdale |
| Adult G | Adult Social Care | Male | 55 | White British | Pennines |
| Adult H | Pennine Care Foundation Trust | Male | 46 | Black African | No Fixed Abode |
| Adult I | Adult Social Care | Male | 54 | British Pakistani | Rochdale |
| Adult K | Adult Social Care | Female | 48 | Black African | Rochdale North |
| Adult L | Adult Social Care | Female | 31 | Black African | Heywood |

* 1. Relevant Themes[[4]](#footnote-4)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Themes | Adult D | Adult E | Adult F | Adult G | Adult H | Adult I | Adult K | Adult L |
| Responses to Substance Misuse | √ | √ |  | √ |  | √ |  |  |
| Pathways concerning Mental Capacity/Executive Capacity/Mental Health | √ | √ | √ | √ | √ | √ | √ | √ |
| Responses to Domestic Abuse/ So-Called Honour-Based Abuse including Forced Marriage | √ |  | √ |  |  |  |  |  |
| Responses when Individuals are Hard to Reach |  | √ | √ | √ | √ | √ | √ | √ |
| Professional Knowledge of Multi-Agency Risk Management /Multi-Disciplinary Team Meetings | √ | √ |  | √ | √ | √ | √ | √ |
| Application of Professional Curiosity (including cultural curiosity) |  | √ | √ | √ | √ | √ | √ | √ |
| Hospital Discharge Procedures |  | √ |  |  | √ |  |  | √ |
| Responses to Mate Crime/Exploitation |  | √ |  | √ |  |  |  |  |
| Bariatric Support |  |  |  |  |  |  |  | √ |
| Professional Consideration of Loneliness |  |  |  |  |  | √ | √ | √ |
| Responses to Self-Neglect |  | √ |  | √ | √ | √ |  | √ |

## **Core information pertaining to the Screening Referrals**

* 1. Referral Source and Wards of Subject

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Screening | Referral Source | Gender of Subject | Age of Subject[[5]](#footnote-5) | Ethnicity | Ward |
| Adult 2 | Adult Social Care | Female | 63 | White British | Pennines |
| Adult 3 | Greater Manchester Police | Female | 37 | White British | Middleton |
| Adult 4 | Adult Social Care | Male | 42 | White British | Rochdale North |
| Adult 5 | Adult Social Care | Female | 73 | White British | Heywood |
| Adult 6 | Adult Social Care[[6]](#footnote-6) | Male | 57 | White British | Pennines |
| Adult 7 | Pennine Care Foundation Trust | Female | 35 | White British | Middleton |
| Adult 8 | Greater Manchester Police | Male | 50 | White British | Rochdale North |
| Adult 1 | Greater Manchester Police | Female | 46 | White British | Middleton |

* 1. Relevant Themes

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Themes | Adult 2 | Adult 3 | Adult 4 | Adult 5 | Adult 6 | Adult 7 | Adult 8 | Adult 1 |
| Substance Misuse | √ | √ | √ | √ | √ | √ | √ |  |
| Mental Health | √ | √ | √ | √ | √ | √ | √ | √ |
| Executive Functioning |  | √ | √ |  |  |  |  |  |
| Dual-Diagnosis |  |  |  |  |  | √ | √ |  |
| Responses to Domestic Abuse/ So-Called Honour-Based Abuse including Forced Marriage |  |  | √ | √ |  |  |  |  |
| Hard to Reach | √ | √ | √ | √ | √ | √ | √ | √ |
| Multi-Agency Risk Management /Multi-Disciplinary Team Meetings |  | √ | √ |  |  | √ |  |  |
| Professional Curiosity |  |  | √ | √ |  |  |  | √ |
| Unsafe Hospital Discharge |  |  |  |  |  | √ |  |  |
| Mate Crime/Exploitation |  |  |  | √ | √ |  |  |  |
| Bariatric Care |  |  |  |  |  |  |  |  |
| Loneliness (including social isolation) | √ | √ | √ |  | √ | √ | √ | √ |
| Neglect (including self-neglect) | √ | √ | √ | √ | √ | √ | √ | √ |
| Financial Abuse |  |  | √ |  | √ |  |  |  |

* 1. As the above table identifies, many of the referrals submitted to Rochdale Borough Safeguarding Adult Board to undergo the screening process (to determine whether the criteria for a SAR was met), were concerned with similar themes to the SARs which were already complete or ongoing and have been referred into this thematic review.
  2. However these screening referrals did not progress into SARs because, whilst the screening panel was in agreement that the subject individual had care and support needs and that there was learning to be identified, a number of the circumstances did not meet the Care Act criteria because there was no information to suggest concerns regarding how the agencies of theRochdale Borough Safeguarding Adult Boardhad worked together to support them.
  3. Other referrals correctly identified that though the SAR criteria was met, because a number of the significant learning points which had been identified through the screening process were already being actioned by Rochdale Borough Safeguarding Adult Board and its member agencies, the learning could be better addressed by other means.
  4. Whilst the non-progression of these screening referrals into SAR processes means that this thematic review is unable to analyse their learning, it is important to include their being within this report as they serve to further highlight the recurrence of concerns and the need for learning developments to improve future practice.

**What can we learn from the Safeguarding Adult Review Overview Reports?**

# **A Summary of the Findings of the SARs by Theme.**

* 1. The overview reports highlighted multiple aspects of practice that could be improved upon which fall within the following thematic matters:

**Professional Response when Individuals are Hard to Reach.**

* 1. Concerns around how professionals engage with individuals featured in all but one of the SARs reviewed.
  2. Some SARs note barriers at the very beginning of a support offer – stating that the most appropriate worker was not assigned and that this immediately affected a worker’s ability to engage with an individual. For example whilst good practice is recognised in Adult I when (where possible) a male worker was provided to support with personal hygiene, Adult I’s worker from STARS had been female and Adult I demonstrated difficulties in accepting personal care support from her. After 9 days, Adult I cancelled the service.
  3. However, even where the most appropriate worker was assigned, an absence of personalised intervention that reflected an understanding of the individual, their lived experiences and their wishes and feelings, was commonly prominent.
  4. In many of the SARs, professionals missed opportunities to learn about an individual’s cultural background. Potentially had this been done, a better understanding of the individual’s experience of being part of a ‘minoritised’ or ‘racialised’ community could have been gained. SAR H further explains why learning about an individual’s culture is necessary: *Understanding someone's culture can help a professional to better empathise. This is important regardless of how long a person has lived in the United Kingdom and/or has sought to integrate, and, in Adult H’s case, could have helped professionals to gain his trust.* In addition, there was a lack of *exploration as to whether there were any external cultural influences impacting upon Adult H’s emotional availability to engage with professionals.*
  5. This is further exampled in SAR K who could have been better supported by more exploration of her cultural influences; Adult K was born and raised in a country where there were no social services and consequently, she may not have understood how rejection of a Social Care assessment could lead to her child becoming cared for. Similarly better exploration of her religious beliefs could have supported professionals to understand some of her behaviours and may have led to better engagement.
  6. The SARs also example how not learning about an individual, creates further challenges in that it hinders respectful uncertainty and encourages the taking of information at face value. The claim of Adult L that she had her sister for support was accepted without challenge, when in reality Adult L had been estranged from her sister for a long time.
  7. A key component to gaining engagement can be to utilise family members and/or friends who may be able to encourage an individual’s participation and voice in decision making and planning. Also family and friends often hold significant information and are able to contribute to care plans, alert professionals when a risk of harm rises, or inform if a change of circumstances occurs. However, many of the SARs evidence a lack of consideration of using family members and friends as aids to engagement and/or protective factors where engagement is proving difficult. For example,
* Adult E had sisters who supported him with his care. There is evidence within the overview report of professionals consulting with them on occasions, but there are missed opportunities to listen and include them more. They reported that *it wasn’t until they threatened to make a formal complaint against the GP Practice that the GP properly listened to their concerns.*
* A family member involved with SAR Adult D expressed *feeling judged by services* and said that *she was not involved or contributed to any care or treatment plan.*
  1. Often the reasoning behind why a family or friend hadn’t been included in care planning isn’t apparent within the SAR reports - though consent to share information is sometimes referred to. This raises the question as to whether professionals lack confidence to explore family/friendships and whether they understand when and what information can be legally shared.
  2. Where there is no one to support an individual, advocacy should be considered. Whilst the SARs show routine consideration of the support of Independent Mental Health Advocates and Independent Mental Capacity Advocates, the use of Independent Advocacy support is a repeated omission. Notably Advocacy Together informed SAR H that many of their referrals are received after a case has been within the professional system for some time.
  3. In some cases, professionals struggled to get past the front door. Covid was cited in many of the SAR reports as a barrier. Individuals purportedly alluded to Covid as a reason not to allow professionals entry into their homes[[7]](#footnote-7) (and not to attend hospital for treatment).
  4. Commonly, the reports evidence that when District Nurses perceived that individuals were proving difficult to engage, they demonstrated good practice by taking their concerns to the daily huddles. This is in line with the Non-Concordance Process which was developed by Northern Care Alliance[[8]](#footnote-8) to support *staff and recipients of care in situations where a person who has mental capacity is making unwise decisions about their health and social care needs, which places them at significant risk of harm.* However there are multiple references to missed opportunities for District Nurses to have made direct Safeguarding referrals to the Trust’s Safeguarding Team. And/or to have discussions with their Safeguarding Team who may have subsequently suggested a professionals meeting convene.
  5. These omissions, regarding not routinely escalating concerns around an individual who professionals are struggling to engage is not limited to District Nurses. It is echoed within the SARs to be an omission of professionals from many agencies.
  6. There is a common consensus throughout the SARs, that mental capacity[[9]](#footnote-9) complicates professional decision-making with regard to escalating concerns because professionals are acutely aware of an individual’s right to ‘unwise’ decisions[[10]](#footnote-10) and their Right to Privacy under Article 8 of the Human Rights Act 1998 (which outlines everyone’s right to respect for their private and family life).
  7. Also, as demonstrated in Adult L and Adult F, in some cases, professionals do not refer such an individual to safeguarding processes as they conclude (in silos) that the circumstances don’t meet the threshold for a Section 42[[11]](#footnote-11) enquiry. In both cases the overview reports conclude that a referral could have still been made and that any professional could have convened and led on a multi-disciplinary meeting to help develop multi-agency understanding and planning.
  8. The SARs highlight that not all professionals understand that they do not need to wait for the section 42 threshold to be reached before convening a multi-disciplinary meeting, or recognise when an individuals’ circumstances could be considered under the Multi-Agency Risk Management process - a protocol that provides professionals with a framework to facilitate effective multi-agency working with adults who are deemed to have mental capacity and who are at risk of serious harm or death, through self-neglect, risk taking behaviour, or refusal of services. (This protocol is discussed further later in the report).
  9. In summary, building a trusting relationship needs time and the SARs reviewed example varying degrees of persistence from professionals. The cases highlight how some professionals, when struggling to engage an individual, feel obliged to accept the refusal of services as an individual’s choice (where the individual has mental capacity) and consequently cease their attempts which often results in case closures.
  10. In some cases, the support of friends and family was not fully utilised, advocacy was not explored and possible barriers such as addiction, mental health, adverse childhood experiences or trauma (such experiences are potential barriers because they may impact upon an individual’s ability to respond to support offers) was not afforded enough consideration. Sometimes the individual’s history was ‘knowable’ in case records, but professionals who were struggling to engage individuals didn’t consult records, or other agencies: *Adult L’s history of Adverse Childhood Experiences could have been explored and acknowledged by the professionals working to support her as an adult. Members of the District Nursing Team who attended the learning event reflected upon how no consideration was (or is) given to looking back at historic notes to help them to understand a patient. And they debated the benefits of doing so when working with someone who is finding it hard to trust professionals.*

***Learning 1: All professionals must be supported (by appropriate training and supervision), to prioritise building relationships of trust with those individuals that they aim to support, who are perceived as avoidant or sometimes hostile. Consideration must be given to choosing the most appropriate worker, utilising an individual’s familial and community support networks and/or advocates, and seeking and exploring potential barriers to engagement that may arise from an individual’s lived experience.***

**Pathways Concerning Mental Capacity and Executive Functioning.**

* 1. There are frequent references within the SARs to professionals assuming individuals to have capacity when able to communicate choices and understand information. Whilst this assumption is proper practice, and it is recognised that a professional will not document every assumption of mental capacity, an issue within the SARs is a lack of documentation regarding an individual who is repeatedly making ‘unwise decisions’ and for whom professionals have increasing concerns. In the absence of a rationale for no further capacity assessment and/or an understanding of what decisions an individual is being asked to make, professionals are not able to see patterns of behaviour, how capacity has previously been fully considered, how often, and whether executive capacity is being taken into account.
  2. For example, a recurring issue within the SARs is the assumption being placed upon an individual having the capacity to make the decision to decline services. Several SARs reference that this capacity has been assumed in line with the Mental Capacity Act Code of Practice whilst documenting the continued efforts of professionals to encourage engagement. Adult L’s assumption of capacity led to her resistance to support not being challenged at all. Instead her self-neglect appears to have been accepted as a choice. This is an example of how repeated assumption of capacity can affect the support offer and should not be accepted without further curiosity. And if doubt remains – further advice should be sought.
  3. There is good practice of professionals questioning decisions around capacity[[12]](#footnote-12) exampled in Adult H, but other SARs evidence how repeated assumption (or in some cases conclusion of capacity after assessment) alongside a continued refusal to engage with support, is too often not escalated and legal advice is not being sought routinely. Legal advice is clearly wise - in the case of Adult H, the legal team recommended the case be referred to the Court of Protection and a referral be made for an Independent Mental Capacity Advocate.
  4. Legal advice should have been sought in the case of Adult G when each of his six assessments concluded him to have capacity to refuse dressing changes, even though he was observed to have a snapped bone in his leg and to be at high risk of sepsis due to scraping his wounds with an unsterile knife.
  5. It is recognised that inherent jurisdiction cannot be used to compel a capacitated individual to do (or not do) something – but in the absence of legal advice being sought, rarely is consideration being given to using the inherent jurisdiction of the High Court. It is notable that the Social Worker in the case of Adult G referenced consideration of inherent jurisdiction, but there is no evidence of legal advice ever being sought.
  6. Executive capacity is a recurrent theme within the SAR reports and a complicated topic within the area of mental health. Several of the SARs make attempts to explain the concept, and the importance of executive capacity is highlighted in SAR E[[13]](#footnote-13) by the report which states; *if executive capacity had been considered, Adult E could* [have been] *found to lack mental capacity in the months prior*. More thought and exploration was required of the difficulties Adult E faced regarding executing his decisions after he had expressed a plan to do so.
  7. Sadly there is a notable omission in that none of the SARs have any good practice examples of professionals understanding and applying their knowledge of executive capacity, and it is beyond the scope of this review to explore whether there are good practice examples outside of the SARs under consideration.
  8. Whilst happily there are examples of Mental Capacity Assessments being undertaken and resulting in best interest decisions, there are examples within the SAR reports of capacity assessment being missed. To illustrate,
* Adult I notes missed opportunities for Adult Social Care to assess Adult I's mental capacity each time Adult I cancelled his care package.
* The Adult E report highlights two potential missed opportunities to formally assess and document Adult E’s capacity and allow for further evidence of his decision making ability.
  1. SAR D suggests that assessment of capacity of an individual who is using substances may be an area of practice in which assessment is being missed; one of the conclusions reached in the review is that there was a lack of exploration of Adult D’s capacity to understand information and risks in particular in terms of her drug use.
  2. Some of the SARs evidence uncertainty as to who is best placed to undertake a mental capacity assessment. Adult I examples how some professionals will defer to Adult Social Care to undertake assessment. Clearly some professionals still look to an agency with more supposed expertise of mental capacity to undertake assessment, despite them having the better understanding of the individual.
  3. Situations within the SARs which involve deprivation of liberty draw little criticism from the Independent Reviewers, with only one SAR noting a missed opportunity for consideration of a Deprivation of Liberty Safeguards application. And good practice around involving deprivation of liberty was highlighted by the panel for SAR D who reportedly believed that the decisions *to compulsorily detain her under the Mental Health Act and then to restrict her liberty using the* deprivation of liberty *procedures were both appropriate and necessary.* The report goes on to say that any restriction on Adult D’s rights or freedom of action was regularly reviewed and only in place for the amount of time necessary to protect her and the public.

***Learning 2: Potentially, because decisions and rationale around mental capacity are not consistently documented, professionals are not always able to recognise where there are repeated uncertainties about an individual’s capacity to make a decision, in order to address them and/or escalate concerns. However, once it has been established that an individual does not have the capacity to make a decision, practice around best interests, deprivation of liberty and the court of protection is mainly efficient and timely.***

**Pathways concerning Mental Health (including Dual Diagnosis).**

* 1. The SARs evidence that it is not unusual for professionals responding to an individual’s mental health to have professional ‘debate’ with regards to next steps. For example, SAR E documents how *prior to Adult E’s last admission to hospital there were discussions between professionals about whether Adult E had mental capacity and if this could be used to transfer him possibly against his will to hospital, or whether he would be conveyed under the Mental Health Act. The GP … felt a Mental Health Act assessment should be the priority. The Approved Mental Health Professional disagreed…The Approved Mental Health Professional felt Adult E’s mental health could be assessed when his physical health was improved.*
  2. Professional debate and challenge regarding mental health is not to be criticised but some of the SARs evidence a confused response to mental health concerns. For example, discussions with the professionals in attendance at the learning event regarding Adult K highlighted *the confusion that frontline professionals* (outside of the mental health service) *have around Mental Health pathways, in particular regarding the differences between a Mental Health Assessment and a Mental Health Act Assessment - within Adult K’s records, the assessment requested around this time is recorded as both a Mental Health Assessment and a Mental Health Act Assessment – which are two very different assessments.* In the end a Mental Health Act Assessment was undertaken with Adult K but during the SAR process, the Approved Mental Health Professional Hub advised that *instead of arranging the Mental Health Act Assessment, it may have been possible to arrange a Mental Health Assessment as a first step towards considering the concerns around Adult K’s mental health.*
  3. Dual diagnosis was not recognised when working to support and engage individuals living with substance misuse and deteriorating mental health and is only mentioned in one of the SARs. Even though as Adult G highlights: *substance use, and addiction can contribute to the development of mental illness and vice versa*.

***Learning 3: It is not unusual for professionals responding to an individual’s mental health to have professional ‘debate’, but some of the SARs evidence a confused response to mental health concerns.***

**Application of Professional Curiosity**

* 1. Professional curiosity, or rather an absence of it, featured in all but one of the SARs and related to professionals not exploring circumstances effectively.
  2. For example, SAR K evidences insufficient professional curiosity in relation to Adult K’s disengagement with her child’s contact sessions; SAR H evidences poor professional curiosity into Adult H’s deteriorating mental health.
  3. Commonly across the SARs, there was absence of professional curiosity into,
* reasons for declining care and support,
* deteriorating poor home conditions,
* circumstances that strongly indicated forced marriage (Adult F).
  1. There was also a failure to explore inconsistencies: in one SAR, family members informed the Independent Reviewer of how they had felt exasperated by the lack of challenge by professionals to their brother’s statements when there was both previous documented and current physical evidence that pointed to the statements their brother was making were either implausible or untrue.
  2. SAR L notes how professionals failed to probe the obvious when Adult L said that she was able to manage her own personal care whilst simultaneously admitting that she was leaving her door unlocked because she was unable to get of bed.
  3. Insufficient professional curiosity regarding how an individual is able to manage at home is repeated with regards to hospital discharges. One SAR notes how when an individual informed hospital staff that he managed well and his sister, who lived next door, supported him, the information was taken at face value despite him having attended hospital with pressure ulcers and in an ‘unkempt state’. Adult Care was not contacted to see what they knew, and the sister was not contacted for corroboration.

***Learning 4: The challenges and barriers to professional curiosity continue and professionals are in need of further support.***

**Responses to Self-Neglect.**

* 1. Though not always recognised, six of the SARs reviewed, included a case of self-neglect – suggesting that it still needs to be better understood.
  2. Rochdale Borough Safeguarding Adult Board has a Self-Neglect and Hoarding Policy which was initially approved in 2018 and is there to be referred to where an adult at risk, with care and support needs, is believed to be self-neglecting. Within its introduction the policy states that *an individual may be considered as self-neglecting and therefore maybe at risk of harm where they are:*
* *Either unable or unwilling to provide adequate care for themselves.*
* *Not engaging with a network of appropriate support*
* *Unable to or unwilling to obtain necessary care to meet their needs.*
* *Following a mental capacity assessment is unable to make reasonable, informed or mentally capacitated decisions due to mental disorder (including hoarding behaviours), illness or an acquired brain injury.*
* *Unable to protect themselves adequately against potential exploitation or abuse.*
* *Refusing essential appropriate support without which their health and safety needs cannot be met, and the individual lacks the insight to recognise this.*
  1. The professionals working around Adult H did not recognise self-neglect. It is the overview report which identifies that; *one avenue that could have been considered was self-neglect in the context of no engagement. This would have allowed the progression of an Adult Safeguarding Referral with services inability to engage Adult H at the forefront of assessment and multi-agency planning.*
  2. The SARs suggest that even where professionals did recognise self-neglect, they were not consistently aware of the policy. However, even where policy was not consulted, ordinarily, professionals recognised that mental capacity was prerequisite.
  3. Whilst mental capacity of the individuals subject to the SARs reviewed was mostly assumed, it is interesting that professionals working around Adult I *agreed that self-neglect was clearer to work with when you could evidence that the pers*on *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.*
  4. Acquiescent with earlier observations highlighted within this report, it does not appear that professionals routinely incorporated consideration of executive capacity into their mental capacity decision-making when considering individuals living with self-neglect.
  5. All too often professionals supporting a capacitated individual who was identified to be self-neglecting offered a single agency response. This usually focussed wholly on addressing a symptom of the self-neglect, i.e., how to gain access to dress a wound, or clean a property, and/or remove or replace items. This response is one that would only ever serve to mask the problem and not identify the underlying drivers to the self-neglect.
  6. However rarely did professionals even manage to ever ‘mask the problem’ as commonly all of the individuals subject to SARs who were considered to be self-neglecting were reported or conceived as difficult for professionals to engage and either refused or cancelled services offered. Universally whilst some professionals had some knowledge of individuals’ lived experiences, no single agency developed a complete overview or full understanding of the causation to self-neglect and/or barriers to support.
  7. In all the self-neglect cases, where there was on-going struggles to engage a person, the increasing risks were not systematically assessed, and concerns not routinely escalated. When professionals did escalate concerns, safeguarding enquiries were conducted and concluded without due consideration or identification of the underlying drivers to the individuals’ behaviours and the circle of self-neglect continued.

***Learning 5: Professional response to an individual (with capacity) who is recognised to self-neglect is often a single agency attempt to address the presenting concern rather than a multi-agency co-ordinated response which seeks to understand and address the underlying drivers. This response is common, regardless of whether professionals have consulted the Rochdale Borough Safeguarding Adult Board Self-Neglect and Hoarding Policy or not.***

**Professional Knowledge of Multi-Agency Risk Management/Multi-Disciplinary Team Meetings.**

* 1. An area that required attention in many of the reviews was information sharing - with many reports referencing missed opportunities for multi-disciplinary team meetings.
  2. Pre dating the SARs under review (in 2015) Rochdale Borough Safeguarding Adult Board introduced their Multi-Agency Risk Management protocol[[14]](#footnote-14). This guidance is to be used where an adult who has the mental capacity to understand the risks posed to them, continues to place themselves at risk of serious harm or death and refuses, or is unable, to engage with health and social care services.
  3. Whilst some SARs reference that not all of the professionals are aware of the Multi-Agency Risk Management Protocol, SAR I identifies that out of the practitioners who attended the Learning Event in November 2022, most were aware. However, even so, some staff working to support Adult I did not refer to the protocol. The overview report identifies the reason as being that staff who had communicated concerns to Adult Social Care, the GP, and/or the care provider believed that was enough to assure that the concerns would be addressed. This presumption that some other agency will initiate necessary safeguarding procedures is reflected in many of the SARs.
  4. Many SARs identify that the Multi-Agency Risk Management Protocol was not followed because professionals did not consider the threshold of *serious harm* *or death* to have been reached. However there are examples within the reports of when, whilst not meeting the threshold for the Multi-Agency Risk Management Protocol, benefit would have been had from convening a Multi-Disciplinary Team Meeting:
* Whilst reviews deemed that the case discharge and service closures resulting from engagement not being achieved or an individual declining services, was in line with policy, there was often a failure to share that the professionals had been unable to engage the individual in support (and that therefore the risk remained unassessed) at the point of service closure.
* In cases of self-neglect, commissioned care agencies were not always fully informed of the individual’s needs.
  1. Positively, in some cases, Multi-Disciplinary Team meetings were convened outside of the Multi-Agency Risk Management Protocol - but where such meetings convened, there was often a collective agreement within the SAR reports that the meetings had lacked robustness and that actions hadn’t been effectively tracked.
  2. The problem identified within the SAR reports regarding following the Multi-Agency Risk Management protocol and the convening of Multi-Disciplinary Team meetings, seems to be one primarily concerned around case leadership. SARs indicate that the omission of a key professional is often resulting in professionals presuming that someone else is instigating safeguarding procedures and/or convening multi-disciplinary meetings. This is also influenced by a poor understanding of each other’s roles and an erroneous understanding of the fact that any professional can convene a Multi-Disciplinary Team meeting or lead on the Multi-Agency Risk Management Protocol.

***Learning 6: There is hesitancy from some professionals (outside of social care) to initiate the Multi-Agency Risk Management Protocol and professional confusion regarding the interpretation of the threshold. Where the threshold of serious harm or death isn’t met, professionals are not affording sufficient consideration to a Multi-Disciplinary Team meeting to assess, plan and manage the care within a multi-agency environment.***

**Responses to Substance Misuse**

* 1. Half of the individuals subject to the SARs under review misused either drugs or alcohol or both. All of these individuals were also known to self-neglect and two of the overview reports comment that the self-neglect was seen as secondary to the substance misuse.
  2. Commonly, professionals recognised substance misuse and referred individuals to specialist support. Though it is important to note that the sister of Adult G informed the SAR of improvements that could be made to such services; she said that *if they were 15 minutes late* [for an appointment] *then they would on occasions be turned away and the treatment record would reflect; did not attend.* Adult G’s sister *felt that expecting people who struggle with substance misuse to be up and organised to attend a morning appointment was to fail to understand the nature of the world the person existed in.*
  3. The SARs indicate a poor professional understanding of how to support hard-to-reach individuals who declined a referral to substance misuse services; there is little evidence of professionals having explored reasons around alcohol or drug misuse, and there is no record of sufficient consideration with respect to other ways to engage an individual with support. The panel of SAR D notes missed opportunities to revisit risk management plans *and consider other approaches and actions, such as for example, engaging with the commissioned provider for substance misuse.*
  4. Notably there is no reference within the SARs of professionals having knowledge of the Blue Light manual[[15]](#footnote-15), which contains a range of advice and tools for professionals working with hard-to-reach drinkers who are not in contact with services.

***Learning 7: Professionals know where to refer individuals who misuse substances for specialist support but need to better consider other approaches and actions where the individual declines.***

**Professional Consideration of Loneliness**

* 1. Adult I cited feelings of loneliness and the report identified that as a result, Adult I was offered community engagement support but declined the offers. Other SARs note factors that could contribute to loneliness but omit to explore how loneliness could potentially affect an individual and/or what support professionals could offer.
  2. For example, it is recorded within the Adult L overview report that Adult L made comments which suggested that she felt shamed by her bariatric needs. The report recognises that these feelings, alongside her loss of mobility, could have led to increasing isolation and potential loneliness[[16]](#footnote-16) and highlights that in an attempt to reduce this, Adult L could have been signpost to the online charity Obesity UK[[17]](#footnote-17) - which besides being a useful resource for professionals, also provides a safe community for people with obesity to communicate. Whilst SAR L notes that loneliness work is currently being undertaken by Rochdale’s Public Health Team, there are missed opportunities within this SAR, and others, to promote the importance of professional practice including exploration of loneliness.

***Learning 8: The SARs have failed to guide professionals to explore whether their practice routinely captures an individual’s loneliness and/or, how well professionals understand the aspects and idiosyncrasies of loneliness.***

**Response to Mate Crime/Exploitation.**

* 1. Two SARs raise the subject of mate crime. Though mate crime can affect many individuals, particularly those with substance abuse issues, mental health issues or learning disabilities, it is a form of abuse/exploitation that continues to challenge professionals and agencies. In reflection of this, both SARs evidence a limited response.
  2. Whilst the safeguarding episode (which was opened when Adult E’s sister contacted the police in relation to fraudulent bank transactions by someone who had befriended Adult E,) was reported to have been managed by Adult Care and the police in accordance with the Rochdale Borough Safeguarding Adult Board policy and procedures– it was closed after a safeguarding protection plan was agreed with actions for Adult E’s sister to apply to be Adult E’s appointee, and Adult Care to refer to a home improvement agency to improve home safety.
  3. Mate crime/exploitation was not expressly identified with regard to Adult G but police, having received calls from both Adult G and from members of the community, identified that reported disturbances were a result of differences between Adult G and his ‘friends’. Because no crimes or offences were disclosed, police had no further action, but neither was further work undertaken by any other agency. Adult G did not ever report that any of these incidents with his ‘friends’ had escalated, but notably he was on one occasion seen with a head injury that wasn’t explained.
  4. Mate crime/exploitation is rarely a one-off incident, and it should never be ignored or minimised. With regards to Adult E, the incident in relation to fraudulent transactions on his bank account by someone who had befriended him, occurred pre the scoping period of the review and little is known other than a safeguarding plan was agreed between the police and Adult Social Care. It is difficult to say whether more could have done based upon the information provided. However with regards to Adult G, whilst there is little information as to whether Police Officers missed any opportunities to share any information with partner agencies, best practice could have seen police requesting a strategy meeting in relation to Section 42 (Care Act 2014) enquiries. This is because whilst the criminal threshold had not been met regarding any crimes against Adult G, there remained, under Section 42 of the Care Act 2014, a legal duty to make enquiries about the safeguarding concerns if Adult G; had needs for care and support, was at risk of ‘abuse’ and, because of his care and support needs, was unable to protect himself from the risk of abuse.
  5. Or had this threshold not been met, police could have convened a multi-disciplinary meeting to share information, review what was known by agencies about Adult G’s circumstances and also to consider any risk to the wider community. This is important becausethe response to possible mate crime/exploitation needs to start with early identification and be multi-agency.
  6. There is no evidence of a multi-agency, co-ordinated approach to resolving any issues pertaining to potential mate crime/exploitation within the SARs.

***Learning 9: There is a lack of professional consideration as to whether an individual in circumstances which indicate potential mate crime/exploitation (when a criminal threshold for prosecution is not met), would benefit from a multi-agency approach.***

**Domestic Abuse/Forced Marriage**

* 1. Only two of the SARs reviewed (Adult F - which was a combined SAR and Domestic Homicide Review and Adult D) feature domestic abuse and/or forced marriage. Whilst the overview reports indicate mostly a good professional understanding of domestic abuse, SAR F raises questions about the recognition of coercive control, and *about the level of professional awareness of what action to take in response to indications of forced marriage amongst partner agencies in Rochdale.* The review made many recommendations around both areas of practice.
  2. SAR F was completed in November 2021, and whether the learning around coercive control and forced marriage has been addressed can only potentially be confirmed with better recording and reporting of data across the partnership, or a thematic review of the Domestic Homicide Reviews (commissioned by Rochdale) since this date.

***Learning 10: In 2021 SAR F raised concerns regarding professional awareness and responses to coercive control and forced marriage.***

**Bariatric Support**

* 1. Only SAR L explores professional practice around bariatric care, but it identifies poor professional exploration of Adult L’s individual’s weight management history and her lived experiences and vulnerabilities.
  2. It is helpful that a Consultant Bariatric Surgeon contributed to SAR L and highlighted how *patients with extreme obesity can present challenges in management as many patients have significant complex psychological issues and may additionally have fixed but erroneous pre-conceptions about bariatric surgery.*
  3. SAR L asks Rochdale Borough Safeguarding Adult Board to consider how it can *learn of the current challenges professionals from all agencies face when attempting to open dialect about a person’s weight management when supporting people experiencing obesity (who are at risk of harm)?* And also to consider how partner agencies can assure them *that their staff are supported within this practice and informed of pathways and procedure?*
  4. At the time of writing this report, due to ongoing coronial court matters, the SAR L overview report has not been published - but it is hoped that upon publication and development of an action plan, improvements to bariatric care will be seen.

***Learning 11: Whilst only SAR L highlights bariatric care, it is clear that professionals need to better incorporate the principles of professional curiosity and how to engage hard to reach individuals, into bariatric care in order to support individuals to talk about their wishes and feelings and gain the confidence to accept support.***

**Hospital Discharge Processes**

* 1. Some of the SARs invite questions about how hospitals plan for discharge.
  2. Unsafe hospital discharge planning resulted in Adult E’s risks and needs not being planned for. And as noted in the overview report, a multi-disciplinary team discharge meeting might have highlighted the self-neglect concerns and achieved planning.
  3. Improved practice was seen in SAR L where, upon the ambulance service reporting home conditions to be cluttered, a safeguarding referral was submitted, and social care completed an assessment prior to discharge. As a result, home care support was offered. Unfortunately the professionals attempting to support Adult L after discharge were unable to effectively engage her – and this is when a multi-disciplinary team meeting would have proved valuable.
  4. Adult H’s discharge proved more complicated due to him having no recourse to public funds and no permanent address. Whilst there was still no discharge planning meeting for Adult H, multi-agency communication is evident, and it is apparent that a Social Worker and staff on the ward attempted to support a safe discharge with the input of homelessness and the Home Office.

***Learning 12: Practice around hospital discharge differs. This is understandable as circumstances vary, but professionals who are involved with a patient’s discharge must remember to incorporate the principles of professional curiosity and refer to safeguarding and/or other support agencies as necessary.***

**The Covid Pandemic**

* 1. It is important to remember that the scoping period timescales for all but three of the SARs under consideration by this review, incorporate the Covid pandemic. The SARs evidence the *everchanging backdrop of the regulations and restrictions introduced to control the Covid pandemic*, and the professional response is explored in detail. It is clear that over time, practices, and communications within the new working conditions became more effective and the ability of staff to adapt is praiseworthy. However, it is also clear that despite the hard work and dedications of professionals, the pandemic had a detrimental effect on service users.
  2. The brothers of Adult I reportedly felt that the Covid 19 pandemic had a negative impact on his physical and mental health. They said that when *Covid restrictions were high, the contact Adult I was able to have with professional's face to face was severely limited*. Though Adult I agreed to telephone consultations in November 2020 he *complained to staff that he felt 'neglected'.* The overview report concludes that *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.*
  3. Other SARs note individuals citing fear of contracting the virus as a reason for not attending hospital or undergoing surgery and it is common across the SARs for individuals to refer to having Covid symptoms as a ‘valid’ reason for not allowing professionals access to property.

# **Conclusions:**

## **A Summary of the Professional Practice and Recognised Developments**

* 1. The initial crux of health and social care support work is the determination of an individual’s mental capacity and consequently all professionals must frequently judge decision-making capacity.
  2. Whilst the SARs evidence much good practice around professional application of the Mental Capacity Act, given its complexities and challenges, it is not surprising that reflection upon the practice has extracted practice areas for improvement. Especially when one considers how the two statutory Codes of Practice[[18]](#footnote-18), (which individuals who are acting in a professional capacity must apply to the Mental Capacity Act 2005), are both deemed to be out of date in significant ways. Accordingly the government is currently updating the Codes of Practice and ran consultation between March 2022 and July 2022. However since then, all those interested have been left awaiting the date for implementation and the final version of the Codes of Practice. And, in April 2023, the Department of Health and Social Care announced that implementation is delayed and likely to be *beyond the life of this Parliament -* that is therefore, likely to be beyond Autumn 2024.
  3. This review is able to confirm that to support its practitioners to apply the Mental Capacity Act, Rochdale Borough Safeguarding Adults Board’s website provides links to the current Code of Practice and various factsheets. In addition, the review has been informed of various agencies providing training to staff and in some cases this training has been amended to incorporate Executive Capacity (or extra optional training has been made available). For example, whilst face-to-face training with regard to the Mental Capacity Act and Deprivation of Liberty Safeguards continues to be provided to all Adult Social Care practitioners, a further supplementary face-to-face awareness course has been implemented, alongside additional specific Executive Functioning training.
  4. Once an individual’s capacity to accept and understand health and/or social care has been decided, support can be offered. The SAR reports evidence that the hurdles professionals now sometimes face is how to support an individual, who has capacity, but who declines services and continues to be at risk of harm.
  5. Understanding an individual, attaining a trusted relationship, and achieving engagement becomes key, and the SARs confirm that this is the common practice area in which professionals struggle. The first support vehicle for this practice lies within a professional’s supervision and team meetings, but a key mechanism through which all agencies and professionals can support one another, is to exchange information, and plan both inter and multi-agency, using policy and practice guidance.
  6. However if safeguarding concerns exist and/or, if following the sharing of information and planning, engagement still proves unachievable (or is not good enough to alleviate safeguarding concerns), professionals must utilise referral processes.
  7. It is a recurring concern within the SARs, that Adult Social Care did not treat all safeguarding referrals as ‘safeguarding’ for the purposes of following the Rochdale Borough Safeguarding Adult Board policy and procedures. Some were treated as ‘care concerns’ which meant that no ‘formal’ multi agency safeguarding enquiries or meetings convened under procedures. This affected further missed opportunities for professionals to be made aware of what information other agencies knew.
  8. Adult Social Care has informed this review that to address this, specific mandatory safeguarding training is in place (which relates to responding to a safeguarding concern) and that completion levels of the training are monitored. In addition, recurrent quarterly audits of recorded safeguarding concerns and of general contacts received, are in place - to quality assure the decision-making. The findings are reported to the quality and assurance sub group who will determine whether any further actions are required before highlighting them to the service development board and senior leadership team through internal governance mechanisms that are already in place.
  9. The Multi-Agency Risk Management Protocol is also there to support professionals in health and social care services with their practice when they are unable to engage an individual who is at risk of serious harm or death. This protocol has been in place since 2015 (prior to the SARs under review) and it has been reviewed at least annually.
  10. However the SARs evidenced that when this threshold is not thought to have been met, professionals need other support and guidance. Hence in August 2023, in response to SAR G and E, Rochdale Borough Safeguarding Adult Board combined the Multi-Agency Risk Management Protocol with a Multi-Disciplinary Team Protocol. This review has been assured of single agency efforts to bring this (and other protocols) to the attention of professionals by means of inclusion in safeguarding training, 7-minute briefings etc. For example Adult Social Care has informed that the Adult Care Safeguarding Training now incorporates the Multi-Agency Risk Management Protocol process.
  11. It is crucial that practitioners understand that the exchange of information and multi-agency planning that both the Multi-Agency Risk Management Protocol and the Multi-Disciplinary Team Protocol bring is essential because to be effective, any support offer must be reflective of the abilities of the individual to whom it is being offered. And the multi-disciplinary meetings directed by both protocols, allow professionals to discuss an individual, start to build a picture of the individual’s lived experience, and identify any barriers (such as substance misuse, mental health, physical health, self-neglect, third party restrictions/influences, poor cognitive skills) which could potentially hinder the individual’s abilities to engage with a support offer.
  12. These barriers (which are often only identified as a result of professionals exchanging information) then require multi-agency planning to be addressed.
  13. Mental health is a common barrier identified within the SARs and professional responses have evidenced some confusion around what type of support is appropriate, and where and how to source help. This review has been informed that Rochdale Borough Safeguarding Adults Board have now updated their mental health pathways and produced guidance which clearly explains the difference between a Mental Health Assessment and a Mental Health Act Assessment.
  14. Commonly in the SARs, when substance misuse has been identified as a barrier, professionals have known which specialist organisations to refer to for support. The problem has been when an individual has been unable to accept the specialised support offer. This review has been assured to hear that Turning Point has recently utilised the Alcohol Change training[[19]](#footnote-19) and as a result all staff have been trained in the “Blue light” alcohol training. A new alcohol pathway is now to be offered which will support ‘change resistant clients’ to be offered harm reduction services without being in treatment.
  15. Self-neglect has been common amongst the individuals subject to the SARs who have been identified to live with poor mental health, and/or substance misuse. Interestingly professionals have more easily identified self-neglect when there has been visible evidence, such as poor home conditions (Adult L, E and G) or hoarding in the home, over self-neglect when an individual has proved unable to meet their own care needs (Adult H).
  16. This is despite Rochdale Borough Safeguarding Adult Board offering a practitioner toolkit with regard to self-neglect which identifies the definition for self-neglect as:
* *Persistent inattention to personal hygiene and /or environment*
* *Repeated refusal of some/ all indicated services which can reasonably be expected to improve quality of life.*
* *Self-endangerment through the manifestation of unsafe behaviours.*
  1. This review has been informed that Rochdale Borough Safeguarding Adult Board has updated its self-neglect and hoarding policy in June 2023 and these renewed documents should support practitioners to better recognise self-neglect.
  2. However the SARs evidence that the overriding problem, with regard to the professional response to self-neglect, is around the confusion professionals have concerning an individual’s right to ‘unwise’ decisions. Professionals report feeling challenged by the ethical dilemma of balancing autonomy with fulfilling a duty of care. This often results in professionals ‘accepting’ an individual’s decline of services which consequences their discharge from the service - leaving an individual without support and hidden from professional sight.
  3. The resultant situation brings us back in a circle to engaging hard to reach individuals, and professional understanding and application of the aforementioned safeguarding referral process, Multi-Agency Risk Management Protocol, and the Multi-Disciplinary Team Protocol (dependent on the level of risk of harm).

## **What More Needs to be Done?**

* 1. It is clear from the analysis of the SARs (and the accompanying information provided) that significant changes to practice have already been developed as a result of the learning identified within the SAR processes. There have been many multi- and single-agency developments within the Rochdale Borough brought to the attention of this review, and these should help professionals to offer individuals the most appropriate and effective support[[20]](#footnote-20).
  2. However, the sample of SARs that this review has considered, highlight how findings and recommendations are being repeated within overview reports and this evidences that action plans previously developed to address the identified learning, have not consistently proved effective. Commonly, an agency’s response to learning is to amend or introduce training packages to their staff. These are now easily delivered, often via eLearning packages, online virtual platforms or Lunch and Learn sessions. This is positive practice, but a common problem identified by practitioners within SAR processes is that their brains become ‘laden’ with learning and/or, such is the variety of their workload, that by the time they need to utilise the learning and put it into practice, their memory has faded due to the passage of time and/or the amount of subsequent training.
  3. It is known that the best training methods target three learning styles:
* visual learning (seeing or watching),
* auditory learning (listening to and absorbing information) and
* kinaesthetic learning (learning through action or by doing).

It is important that Rochdale Borough Safeguarding Adult Board, its partner agencies, and organisations working within its area to support adults at risk, seek to understand what works best for their staff and tailor their learning material appropriately.

**Question 1 for Rochdale Borough Safeguarding Adult Board:**

**How can Rochdale Borough Safeguarding Adult Board, and its partner agencies, gain an understanding as to why action plans, developed in response to previous commissioned SARs, have not proved effective? And how can partner agencies evidence to Rochdale Borough Safeguarding Adult Board that their training is being offered in formats agreeable to their professionals?**

* 1. A number of the SARs note practice that was not in line with actions that would be expected under Rochdale Borough Safeguarding Adut Board policies and procedures. For example, several found that actions taken were not consistent with the Multi-Agency Risk Management Protocol. This raises questions around how guidance is embedded within local agencies. Participants at the learning event for one SAR wondered whether policies and procedures would achieve greater traction if they were simplified or shortened. At a similar event for another SAR, participants indicated that they had found the self-neglect policy hard to understand.
  2. More effective policies and procedures would support improved multi-agency working arrangements and address the issues highlighted around agencies working in silos and missing opportunities to convene multi-disciplinary meetings and commence a multi-agency approach.
  3. In summary, the SARs emphasise the need for a proactive follow up by the Board in relation to the development and implementation of its procedures.

**Question 2 for Rochdale Borough Safeguarding Adult Board:**

**How can Rochdale Borough Safeguarding Adult Board evidence that their policies and procedures are easy for professionals[[21]](#footnote-21) to locate and that professionals are finding them comprehendible, clearly expressed, and memorable?**

* 1. This review has been assured by Rochdale Borough Safeguarding Adult Board that focus is already upon improving multi-agency working arrangements by means of a new Model of Safeguarding currently under development, to be known as Team Around the Adult.
  2. Team Around the Adult (which is hoped to be launch in September 2024) is described *as a multi-agency method of work to create good outcomes for adults with support needs who may not require statutory safeguarding.* It involves*, a multi-agency approach* which *is proactive in joint assessment, planning and preventing escalation of risk.*
  3. In addition, Greater Manchester Police has informed this review of a new partnership approach currently being designed nationally called Right Care, Right Person. This approach aims for individuals to be responded to by the right person, with the right skills, training, and experience (from the right organisation) at the earliest opportunity.
  4. Rochdale Borough Safeguarding Adult Board has an opportunity to include a proactive follow up in relation to the development and implementation of its procedures and to incorporate the learning identified within this thematic review within their new model, Team Around the Adult. However Rochdale Borough Safeguarding Adult Board, with the support of Greater Manchester Police, must ensure that the ensuing action plan is workable within both of the two new models currently being developed, and that the completed model is made widely known.

**Question 3 for Rochdale Borough Safeguarding Adult Board:**

**How can Rochdale Borough Safeguarding Adult Board evidence that the new safeguarding model, Team Around the Adult, will reach the professionals and staff working within their partner agencies.**

* 1. Finally, this review has identified the key areas of professional practice which have been recommended for improvement by the SARs. They include engaging individuals who are hard to reach (whether that be in safeguarding enquiry or specialist support, for example, alcohol misuse or weight management), information seeking and sharing, the personal responsibility to lead and use case management protocols, multi-agency case escalation, and identification of the underlying drivers of self-neglect. The aforementioned developments to practice will go a long way in addressing these aspects of practice but it is important that the effectiveness of the developments on practice is monitored and audited effectively.
  2. The following table identifies what further developments to practice could support the practitioners and staff working for agencies and organisations within the Rochdale Borough to safeguard the individuals within their communities.
  3. This review would ask Rochdale Borough Safeguarding Adult Board and its partner agencies to consider the outstanding concerns identified within the table and use the ensuing debate to model an action plan to support further improvements to systems and practice.

**Question 4 for Rochdale Borough Safeguarding Adult Board:**

**How can Rochdale Borough Safeguarding Adult Board address the outstanding concerns identified within the** [**table on pages 23-2**](#table)**7 of this report, and how can the effectiveness of the resulting actions on professional practice, be monitored (the actions should be developed in consideration with question 1)?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Collective Learning from Analysis of the SARs** | **What Practice Developments have been put in place since the Scoping Periods of the SARs, to address the Learning?** | **Are there Outstanding Concerns and How Could they be Addressed?** |
| 1 | All professionals must be supported (by appropriate training and supervision), to prioritise building relationships of trust with those individuals that they aim to support, who are perceived as avoidant or sometimes hostile. Consideration must be given to choosing the most appropriate worker, utilising an individual’s familial and community support networks and/or advocates, and seeking and exploring potential barriers to engagement that may arise from an individual’s lived experience. | In the main agencies have concluded that the practice issues which have arisen from how to engage hard to reach individuals and build relationships of trust can be addressed with improved professional curiosity. Agency action plans consequently demonstrate that training sessions have been delivered and information/guidance shared on the subject of professional curiosity. | Whilst improved professional curiosity is always a good thing and will support professionals to explore potential barriers to engagement, its promotion will not support or remind professionals to consider utilising friends/family/advocacy or help them to recognise when to discuss an individual within a multi-disciplinary team meeting or escalate concerns around engagement as a safeguarding concern. Guidance for professionals struggling to achieve engagement - with prompts to consider friends/family/advocacy and examples of when a situation warrants a multi-disciplinary meeting or safeguarding concern could instil confidence into a professional when trying to achieve engagement. Furthermore highlighting examples of good practice could prove inspiring, such as that accentuated in Adult H which said *the judge gained Adult H’s trust by starting their conversation with superfluous discussion of inconsequential subject. In Adult H’s case it was football. Such conversation appeared to put Adult H at ease, and one professional at the learning event commented that the judge learned more about Adult H in their short conversation than other professionals did who had been trying to engage Adult H for weeks.* Examples could also be sought from outside the Rochdale Borough. |
| 2 | Potentially because decisions and rationale around mental capacity are not consistently documented, professionals are not always able to recognise where there are repeated uncertainties about an individual’s capacity to make a decision, in order to address them and/or escalate concerns. However, once it has been established that an individual does not have the capacity to make a decision, practice around best interests, deprivation of liberty and the court of protection is mainly efficient and timely. | As mentioned, Rochdale Borough Safeguarding Adults Board’s website provides links to the current Code of Practice and various factsheets. In addition many agencies have provided training to staff and in some cases this training has been amended to incorporate Executive Capacity (or extra optional training has been made available). | It would be prudent to ask agencies to confirm whether the mental capacity training and guidance that they have delivered, incorporates the importance of documenting:   * the specifics of what decision individuals were being assessed or assumed to have the capacity to decide, and * the professional rationale of the outcome. |
| 3 | It is not unusual for professionals responding to an individual’s mental health to have professional ‘debate’, but some of the SARs evidence a confused response to mental health concerns. | Rochdale Borough Safeguarding Adults Board has now updated its mental health pathways and produced guidance which explains the difference between a Mental Health Assessment and a Mental Health Act Assessment. | Rochdale Borough Safeguarding Adult Board will need to ensure that the updated mental health pathways and guidance is cascaded to professionals and serves to improve future practice. |
| 4 | The challenges and barriers to professional curiosity continue and professionals are in need of further support. | As noted at learning point 1, agency action plans demonstrate that training sessions have been delivered and information/guidance shared on the subject of professional curiosity | Professionals are mostly able to inform that professional curiosity means; not accepting a single source of information at face value, and triangulating information from different sources. What is needed for agencies to improve future practice is an understanding of the barriers professionals face when incorporating professional curiosity into practice. For example, are professionals confident in managing any arising tension? Is the pressure of work to blame? Fixed thinking or unconscious bias? Are barriers created by changes of workers which can lead to a “starting again” situation; or because cases are closed too quickly? This greater understanding - achievable only through open consultation with frontline professionals, will inform how to support professionals to improve their future practice. |
| 5 | Professional response to an individual (with capacity) who is recognised to self-neglect is often a single agency attempt to address the presenting concern rather than a multi-agency co-ordinated response which seeks to understand and address the underlying drivers. This response is common, regardless of whether professionals have consulted the Rochdale Borough Safeguarding Adult Board Self-Neglect and Hoarding Policy or not. | Rochdale Borough Safeguarding Adult Board offers a practitioner toolkit with regard to self-neglect and has updated its self-neglect and hoarding policy in June 2023. | It is positive that there are now clear pathways and guidance for those working with individuals who self-neglect, but sadly the SARs evidence that there are times - even when professionals have consulted the toolkit and followed the pathways - when the intervention hasn’t been successful or has potentially come too late. This is sometimes concluded to be partly attributable to agencies working too long in silos as better outcomes are achievable if multiple agencies contribute to planning but professionals have helpfully informed that a barrier to progressing self-neglect cases into a multi-agency arena is that they struggle to balance autonomy with duty of care. Whilst the term self-neglect comes from the definition within the Care Act 2014, it is a term that implies a lifestyle choice in that an individual is choosing not to care for themselves. Consequently, maybe a good starting point to help professionals move away from so called self-neglect being an individual’s choice, would be consideration of the language and terminology used. Could the inclusion of another word, for example, ‘involuntary’ self-neglect, within Rochdale Borough’s professionals’ guidance serve as a reminder to professionals to explore underlying causes and/or support the removal of any unconscious bias? To help them with this, professionals may also benefit from having access to examples of good/successful practice and/or opportunity to share their own experiences. This could encourage/inspire them to try new and creative methods to achieve improved practice in this area of their work. In summary, professionals may benefit from a revamped approach to the support they are offered to help them to recognise and respond to self-neglect. |
| 6 | There is hesitancy from some professionals (outside of social care) to initiate the Multi-Agency Risk Management Protocol and professional confusion regarding the interpretation of the threshold. Where the threshold of serious harm or death isn’t met, professionals are not affording sufficient consideration to a Multi-Disciplinary Team meeting to assess, plan and manage the care within a multi-agency environment. | In August 2023, Rochdale Borough Safeguarding Adult Board combined the Multi-Agency Risk Management Protocol with a Multi-Disciplinary Team Protocol. This review has been assured of single agency efforts to bring the protocol to the attention of professionals by means of inclusion in safeguarding training, 7-minute briefings etc. | The effectiveness of the combined protocol on practice will need to be monitored and evidenced. |
| 7 | Professionals know where to refer individuals who misuse substances for specialist support but need to better consider other approaches and actions where the individual declines. | Turning Point has recently utilised the Alcohol Change / Blue Light training. | In 2015 Alcohol Concern launched the Blue Light Project[[22]](#footnote-22) which sought to support hard-to-reach drinkers, who fit into three criteria: alcohol dependent, a burden on public services and non-engagement with treatment. The Blue Light approach *challenges the belief that only drinkers who show clear motivation to change can be helped* and sets out tools and techniques that can be used with this group. At the heart of Blue Light is a manual[[23]](#footnote-23), which sets out key principles and contains a range of advice and tools for working with clients who are not in contact with services. Training and/or the manual could be utilised by professionals outside of Turning Point. Whilst the manual is a model of care for alcohol misusers it challenges the notion that ‘nothing can be done’ when individuals are treatment resistant – as such its principles could be applied to individuals who misuse other substances. |
| 8 | The SARs have failed to guide professionals to explore whether their practice routinely captures an individual’s loneliness and/or how well professionals understand the aspects and idiosyncrasies of loneliness. | Adult I recommended that Rochdale Borough Safeguarding Adult Board 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. This review has been informed that this work is ongoing.  Also Public Health has commissioned Civil Society Commissioning to create train the trainer sessions. Rochdale Borough Safeguarding Adult Board is recruiting trainers. | Rochdale Borough Safeguarding Adult Board will need to ensure that the training is embedded into practice.  Consideration could also be had as to how practitioners could be supported to gain an understanding of intersectionality - a sociological framework for understanding how aspects of individual identity, for example, ethnicity, gender, sexuality, religion, disability, weight – interact to create experiences of discrimination or privilege. |
| 9 | There is a lack of professional consideration as to whether an individual in circumstances which indicate potential mate crime/exploitation (when a criminal threshold for prosecution is not met), would benefit from a multi-agency approach. | The promotion of the combined Multi-Agency Risk Management Protocol and Multi-Disciplinary Team Protocol could help – but this is dependent upon professionals recognising the risk. | Rochdale Borough Safeguarding Adult Board and its partner agencies could benefit from a specific developed toolkit and pathway to raise awareness of mate crime/exploitation and guide professional response, in particular - when the circumstances do not meet the criminal threshold for prosecution. Such a toolkit/pathway could include:   * locally agreed definitions of mate crime/exploitation. * examples of the flags which support early identification. * guidance to multi-agency planning. * safeguarding actions for consideration, i.e., consensual relocation, access to mobile telephone, address markers, target hardening by a housing provider. * direction with regard to senior management oversight * signposting to the Multi-Agency Risk Management Protocol and Multi-Disciplinary Team Protocol   Following finalisation of any toolkit/pathway Rochdale Borough Safeguarding Adult Board should roll out multi-agency training. |
| 10 | In 2021 SAR F raised concerns regarding professional awareness and responses to coercive control and forced marriage. | An action plan was produced in response to the concerns raised by SAR F. | As mentioned, whether the learning has been addressed can only be confirmed with a thematic review of Domestic Homicide Reviews commissioned by Rochdale, or better recording and reporting of data across the partnership. |
| 11 | Whilst only SAR L highlights bariatric care, it is clear that professionals need to better incorporate the principles of professional curiosity and how to engage hard to reach individuals into bariatric care in order to support individuals to talk about their wishes and feelings and gain the confidence to accept support. | The action plan for SAR Adult L is under consideration at the time of writing this report. |  |
| 12 | Practice around hospital discharge differs. This is understandable as circumstances vary, but professionals who are involved with a patient’s discharge must remember to incorporate the principles of professional curiosity and refer to safeguarding and/or other support agencies as necessary. | Northern Care Alliance report feeling satisfied that new measures are in place, particularly around communication pathways, and especially the Trusted Assessor pathway and ensuring that the Transfer of Care team are involved in working with clinical staff in clinical areas to co-ordinate other agencies. | The effectiveness of the new measures must be evidenced. |

# **Appendix A**

Panel membership includes:

* The Independent Reviewer
* A representative from Adult Social Care
* A representative from Greater Manchester Integrated Care Board
* A representative from Greater Manchester Police
* Representatives from Rochdale Borough Safeguarding Adult Board

# **Appendix B**

**Adult D**

At the time of her death Adult D was living in supported accommodation. Children’s Services were involved with her, and she had transitioned to Adult Care. Adult D had suffered adverse childhood experiences and had been the victim of sexual exploitation. She had a chaotic history that included behaviour which put her at risk of serious harm. This included self-harm, overdoses of various substances (including proprietary, prescribed, and illicit drugs), attempts to commit suicide and excessive consumption of alcohol. In late 2018, North West Ambulance Service received a call to attend an address. Adult D was found deceased in a chair and pronounced dead. A police investigation did not disclose any evidence of crime and Her Majesty’s Coroner authorised a post mortem which established the cause of death as: 1a) Combined drugs toxicity.

**Adult E**

Adult E was 72 years of age when he was admitted to hospital following a significant decline in his ability to care for himself at home. Adult E had experienced a fall in 2008 whereby he had sustained a head injury which required a brief period of care in a residential home until Adult E was well enough to return to his own home with the support of his 2 sisters. Following this his alcohol intake had gradually increased, and his sisters felt he was starting to show signs of mental health problems including depression. Adult E’s self-neglect continued to increase significantly - resulting in the North West Ambulance Service submitting four safeguarding referrals to the Local Authority between June and October 2019. In October 2019 Adult E was admitted to hospital after the ambulance service attended his home and found him with clothing stuck to his skin and his sofa rotting away underneath him. Adult E spent 55 days in hospital receiving treatment for pressure ulcers before being transferred to a nursing home.

**Adult F**

Adult F died after hanging herself in the bedroom of the home she had shared with her father and brother for most of her life. There was considerable conflict in the relationship between Adult F and her father and brother which led to numerous police attendances at the address they shared. Adult F made several disclosures of domestic abuse against her brother and her father although no successful prosecutions resulted. During the final months of her life, Adult F sought assistance from a wide range of agencies which gave rise to concerns that she may be subject to coercion and control, that she may be at risk of forced marriage and that she was experiencing adverse physical and mental health including suicidal ideation.

**Adult G**

Adult G was 55 when he died. He had first become known to the Community Drug Team when he had been in his late twenties. At this time he had described trying various drugs as a teenager, including glue sniffing and serious regular drug use from age 20 which included cannabis. He first reported using heroin at age 24 and crack cocaine from age 26. Around 2015/2016 Adult G was self-reportedly smoking heroin between 2-3 times a week and he was also noted to be drinking alcohol daily at hazardous levels. His physical health deteriorated, and he developed significant leg ulcers to both legs and experienced circulatory difficulties. Professionals struggled to engage Adult G and his self-care and home conditions worsened. In July 2020 District Nurses found a bone visible on Adult G’s leg that appeared to be snapped but Adult G still refused to go to hospital. At the time there were no concerns about Adult G’s capacity to make this decision but in December 2020, Adult G’s sister called the ambulance service as she was concerned about the deterioration in her brother’s health. Adult G was confused and lacking capacity. He was transferred to hospital and treatment commenced under a best interest decision. Sadly Adult G did not respond to treatment and died.

**Adult H**

Adult H came to live in the United Kingdom from Africa in 2005, but a year later was refused Indefinite Leave to Remain. Following a prison sentence in 2012 for fraud offences committed in 2009, he was made subject of a deportation order but was offered voluntary deportation due to unrest in his home country. For reasons unknown, Adult H did not apply for asylum and was consequently left without recourse to public funds. In November 2020 Adult H was admitted into hospital under section 2 of the Mental Health Act. Staff at the hospital were unaware that Adult H lived with Human Immunodeficiency Virus and had stopped taking his prescribed medication for several weeks. Following Adult H’s detainment under section 2 expiring, and healthcare professionals deeming no evidence of enduring mental illness, Adult H was discharged from hospital. Professionals had been unable to successfully engage him with care or support. A week later Adult H was readmitted and deemed to require bilateral leg amputation and a blood transfusion. Adult H refused both. In January 2021 a Judge determined that Adult H lacked capacity to make decisions about his medical needs, and that surgery should go ahead in Adult H’s best interests. Sadly, post-surgery, Adult H’s health deteriorated, and he passed away.

**Adult I**

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 had been discharged due to lack of engagement. He had spent a considerable length of time as an adult using cannabis to relieve the 'physical pain' he was experiencing and was noted to be a heavy smoker. Adult I drank to excess at various periods in his life. Following an assessment of Adult I's needs in June 2021 it was agreed that a support package would be provided to support him with meal preparation, medication prompts, shopping, and personal care. Homecare support was provided to Adult I from June 2021 but in February 2022 Adult I sadly died.

**Adult K**

Following an escalation of concerns in respect of Adult K’s ability to meet her child’s needs her child was removed from her care. Concerns were raised regarding Adult K’s mental health but an On-Call Psychiatrist and Section 12 Approved Doctor who urgently attended her, assessed that Adult K did not meet the requirements to be sectioned. Whilst Adult K initially engaged with contacts arranged for her to see her child, her contact later ceased and the Children With Disabilities Team thereafter found Adult K hard to reach. In August 2022, two housing officers from Rochdale Borough Neighbourhood Housing attended Adult K’s address due to an unpaid housing debt. When the officers managed to gain entry to the address, they found Adult K in a decomposed state.

**Adult L**

Adult L came to the United Kingdom with her mother and siblings from Africa, to seek asylum, when she was around 12 years old. In 2005, following a period of Child in Need support, Adult L was accommodated into Local Authority Care. When Adult L turned 18 years of age, she moved to Rochdale initially in supported living accommodations. Adult L lived with long standing issues with weight management, and by the scoping period of this review was a bariatric patient. She also experienced chronic back pain, ulcers to the back of her legs, anxiety, and depression. In 2021, when Adult L was admitted into hospital with sepsis, her home was reported to be unkempt and cluttered and there was evidence of poor personal hygiene. A safeguarding referral was made but following Adult L’s discharge from hospital, support services only achieved a limited engagement and Adult L’s property deteriorated to an unkempt and malodorous condition. Adult L agreed to her property undergoing a deep clean but following a Care Act Assessment being completed by Adult Social Care, she declined further support. Adult L was deemed to have capacity to make this decision. In September 2022 after a Housing Officer had visited Adult L and become concerned, Rochdale Borough Housing submitted a Safeguarding Referral. Consequently, a duty Social Worker communicated with Adult L, who then agreed to allow nurses into her home and to consider mental health support if delivered by telephone. Unfortunately, nurses still did not achieve physical access and on the 14th of November 2022, Adult L was sadly found deceased in her bed.

# **Addendum to the Thematic Analysis of SARs**

(Added September 2024.)

## **Circumstances Leading to the Addendum**

* 1. During completion of this Thematic Analysis of SARs, Rochdale Borough Safeguarding Adult Board received a further Safeguarding Adult Review referral in relation to a married male (PC) and female (JC) aged 68 and 66 respectively.
  2. Consequently, a multi-agency Safeguarding Adult Review screening meeting convened to,
* determine the level of involvement which agencies had with PC and JC,
* the known circumstances leading up to their deaths, and
* examine whether criteria had been met for either individual to become subject to a Safeguarding Adult Review.
  1. In brief, PC and JC’s circumstances are:
     1. PC had historically suffered a stroke and lived with type 2 diabetes. JC, was his carer.
     2. In October 2023 PC underwent an operation to amputate his foot. District Nurses attending the couple’s property to dress the wound post-op, soon became concerned about the home conditions and submitted safeguarding concerns to Adult Social Care outlining rubbish in the property, hoarding, flies, maggots, faeces, vomit and urine. The home was described as a ‘health hazard’.
     3. On a day in January 2024, District Nurses entered the property and found JC naked on the floor. She was taken to hospital but sadly passed away a few days later. HM Coroner did not hold an inquest into her death, but malnutrition is recorded to have been a factor.
     4. The following day PC was admitted into hospital with vascular issues[[24]](#footnote-24)/a necrotic leg[[25]](#footnote-25). PC also sadly passed away a few weeks later. HM Coroner concluded the death to be of natural causes.
     5. Within this short timescale outlined, safeguarding referrals and concerns had been submitted to Adult Social Care by the District Nurses (on four occasions), the ambulance service (twice), the hospital (twice), the police service (once) and a family member (once). It is recorded that the couple mostly declined support offered.
  2. All attendees at the screening panel, agreed that the circumstances for both individuals met the criteria for a Safeguarding Adult Review as per the Care Act 2014. However it was also recognised that the learning highlighted within the screening process (in particular with regard to ‘self-neglect’ and individuals whom professionals find it difficult to engage in support offers) echoed learning already identified in other Safeguarding Adult Reviews and Safeguarding Screening processes undertaken by Rochdale Borough Safeguarding Adult Board and explored collectively within the recently completed Rochdale Borough Safeguarding Adult Board Analysis of SARs.
  3. Consequently the Analysis of SARs, to which this is an addendum, will now also recommend that to compliment the work outlined at paragraph 4.8[[26]](#footnote-26) of its report, additional scrutiny is devised into safeguarding referrals. That is; how they are referred, responded to, and managed.
  4. This is essential to ensure that agencies are working together effectively to protect adults at risk.
  5. This additional scrutiny will be achieved by means of a Multi-Agency Audit for Safeguarding Referrals.

## **Objectives of the Multi-Agency Audit for Safeguarding Referrals**

* 1. The purpose of the Multi-Agency Audit commissioned by the Rochdale Borough Safeguarding Adult Board is to:
* Highlight in a quantifiable way which aspects of safeguarding referrals are working well, and which are causing concern.
* Evidence the key issues with examples which provide a qualitative analysis of the issues.
* Draw together themes and make recommendations.

## **Methodology**

* 1. Upon the recommendation for a Multi-Agency Audit, the Independent Reviewer and Rochdale Borough Safeguarding Adult Board met to discuss and develop a multi-agency audit tool, which would support the identification of safeguarding concerns raised in relation to the eight adults included within the Analysis of SARs review and also PC and JC.
  2. The bespoke audit was then completed on behalf of Rochdale Borough Safeguarding Adult Board using the Safeguarding Adult Reviews’ chronologies which had been supplied for the Analysis of SARs review.
  3. The chronologies were examined for referrals made by agencies to Adult Social Care and the data was submitted to the Adult Social Care Serious Incident Review Officer, who checked it against Adult Social Care records to establish whether and how the referrals had been received, and what if anything had been recorded on the database.
  4. This initial assessment is essential to the Multi-Agency Audit and will provide the platform for extended audit, discussions and analysis within and across agencies working in in the Rochdale Borough, in order to develop and strengthen existing safeguarding referral practice.

## **Outcome**

* 1. Using the findings from the Multi-Agency Thematic Audit, a panel of safeguarding leads from all agencies will create an effective Learning Outcome document. This will be overseen and reviewed by the Safeguarding Adult Review sub group.
  2. The Safeguarding Adult Board members will take ultimate responsibility for sharing the learning and after an agreed period (usually between 6-12 months) the Audit Co-ordinators and Rochdale Borough Safeguarding Adult Board will produce a Multi-Agency Audit update report which will reflect the progression of the agreed action plan.

1. A brief overview of each SAR can be found at Appendix B [↑](#footnote-ref-1)
2. Adult F is a combined Safeguarding Adult Review and Domestic Homicide Review [↑](#footnote-ref-2)
3. At time of death/significant incident [↑](#footnote-ref-3)
4. As identified by the Independent Reviewer of this report. [↑](#footnote-ref-4)
5. At time of death/significant incident [↑](#footnote-ref-5)
6. Following Drug Death Overview Panel [↑](#footnote-ref-6)
7. Professionals debated how Covid provided a legitimate reason for them not to gain access to Adult L’s property who sometimes deferred contact by stating that she had Covid symptoms or was feeling unwell. [↑](#footnote-ref-7)
8. Issued in April 2020. [↑](#footnote-ref-8)
9. Application of the Mental Capacity Act is considered elsewhere in this report. [↑](#footnote-ref-9)
10. There is a useful article which may support professionals around this: https://www.communitycare.co.uk/2019/06/28/misinterpretation-unwise-decisions-principle-illustrates-value-legal-literacy-social-workers/ [↑](#footnote-ref-10)
11. Under Section 42 of the Care Act 2014, local authorities have a duty to make, or cause to be made, enquiries in cases where they reasonably suspect that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect, and, as a result of those needs, is unable to protect themselves from this actual or risk of abuse and neglect. [↑](#footnote-ref-11)
12. When after a Mental Health Liaison Team consultant had concluded that Adult H did have capacity, the medical team still being unsure decided to contact the hospital legal team for advice and guidance. [↑](#footnote-ref-12)
13. Adult E frequently agreed to have care support but then repeatedly failed to engage, stating he was ‘ok’. [↑](#footnote-ref-13)
14. Both protocols are published on the website - [Rochdale Safeguarding Partnership Board - Multi-Agency Policy, Procedures, Protocols and Guidance](https://rochdalesafeguarding.com/p/resources-and-tools/multi-agency-policy-procedures-protocols-and-guidance). [↑](#footnote-ref-14)
15. [The-Blue-Light-Manual.pdf](https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/The-Blue-Light-Manual.pdf) [↑](#footnote-ref-15)
16. While loneliness is a common experience when it is long-term and enduring it can have a serious, detrimental effect on our mental health and it must be taken seriously. [Loneliness policy briefing - England | Mental Health Foundation](https://www.mentalhealth.org.uk/our-work/policy-and-advocacy/loneliness-policy-briefing-england) [↑](#footnote-ref-16)
17. [Obesity UK](https://www.obesityuk.org.uk/) [↑](#footnote-ref-17)
18. One for the main body of the Act, and one for the Deprivation of Liberty Safeguards [↑](#footnote-ref-18)
19. [Training | Alcohol Change UK](https://alcoholchange.org.uk/help-and-support/training) [↑](#footnote-ref-19)
20. This review recognises that, at the time of writing this report, not all of the action plans had been fully developed and consequently there are more developments to come in the near future (it would respectfully remind Rochdale Borough Safeguarding Adults Board to explore the most recent developments to practice when considering their action plan for this thematic review - to avoid unnecessary duplication). [↑](#footnote-ref-20)
21. Some agencies work across different areas of Greater Manchester necessitating consultation being had with other areas when developing this action plan. [↑](#footnote-ref-21)
22. [The Blue Light Project | Alcohol Change UK](https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project) [↑](#footnote-ref-22)
23. [The-Blue-Light-Manual.pdf](https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/The-Blue-Light-Manual.pdf) [↑](#footnote-ref-23)
24. Conditions that affect the blood vessels in the body [↑](#footnote-ref-24)
25. A necrotic leg is a leg that has necrotic tissue, which is dead tissue that forms when not enough blood and oxygen reach the affected tissues. [↑](#footnote-ref-25)
26. Adult Social Care informed the review of specific mandatory safeguarding training relating to responding to a safeguarding concern. They reassured that completion levels of the training are being monitored and that in addition, recurrent quarterly audits of recorded safeguarding concerns and of general contacts received, are in place - to quality assure the decision-making. The findings are then reported to the quality and assurance sub group who will determine whether any further actions are required before highlighting them to the service development board and senior leadership team through internal governance mechanisms that are already in place. [↑](#footnote-ref-26)